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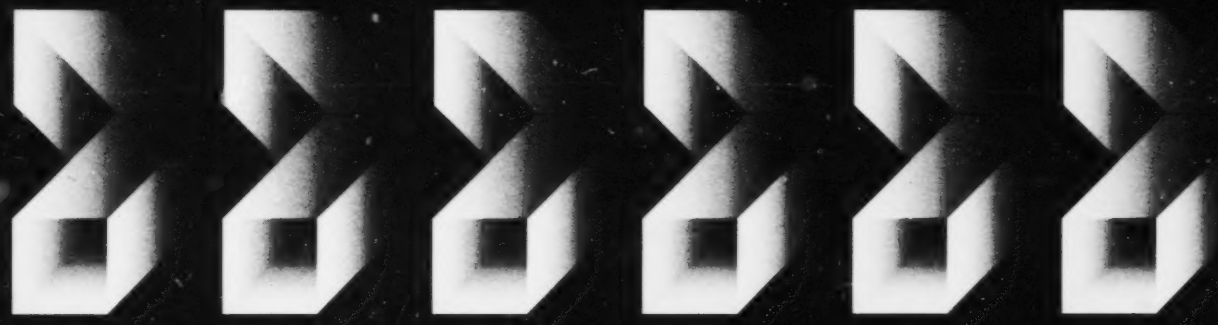

MID-TERM REVIEW OF CANADA'S DRUG STRATEGY

INTER-DEPARTMENTAL EXECUTIVE SUMMARY AND RECOMMENDATIONS

November 1996

PLEASE NOTE:

THE EXECUTIVE SUMMARY, WHICH INCLUDES THE RECOMMENDATIONS OF THIS STUDY, IS A PROTECTED DOCUMENT, AND IS NOT FOR PUBLIC DISTRIBUTION.

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MISSION STATEMENT

The Evaluation Group helps Health Canada serve Canadians better by providing objective information and advice about the effectiveness of departmental activities and services.

ÉNONCÉ DE MISSION

Le Groupe de l'évaluation aide Santé Canada à mieux servir les Canadiens et les Canadiennes en offrant une information et des conseils objectifs sur l'efficacité des activités et des services du Ministère.

INTER-DEPARTMENTAL EXECUTIVE SUMMARY AND RECOMMENDATIONS

MID-TERM REVIEW OF CANADA'S DRUG STRATEGY

NOVEMBER, 1996

executive summary and recommendations

WHAT IS CANADA'S DRUG STRATEGY?

Canada's Drug Strategy is a five year inter-departmental initiative intended to improve the effectiveness of Canada's psychoactive drug programming. A predecessor initiative, the National Drug Strategy, began in 1987 and expired in March, 1992. Canada's Drug Strategy is a renewal and modest modification of the original National Drug Strategy and is often referred to as Phase II of Canada's Drug Strategy.

This initiative can be regarded somewhat as an experiment in federal government program design. The Strategy represents, at least in theory, an attempt to add value to existing programs, and not only by supplementing their funds or adding new programs. Canada's Drug Strategy, rather, is to improve the effectiveness of existing programming by introducing a strong measure of co-ordination, and by attempting to work "smarter" through targeting programs to specific sub-populations in order to reap the greatest benefit for the money invested and by improving the information upon which policy and programming decisions are made. An important question for evaluating this initiative is to what extent has Canada's Drug Strategy actually become more than the sum of its parts? Is the Strategy more than just a set of independent programs linked through a common Memorandum to Cabinet that authorizes supplementary funding? There are many federal inter-departmental programs now; the experiences of Canada's Drug Strategy should be of benefit to the others, and it is hoped that some of the findings of this mid-term review, especially with regard to co-ordination, will be useful to the other initiatives.

The federal departments participating in the Strategy are:

- Health Canada
- Solicitor General Canada, which includes the RCMP and Correctional Service Canada
- Revenue Canada, Customs, Excise and Taxation
- Human Resources Development Canada
- Department of Foreign Affairs and International Trade
- Justice Canada
- Canadian Heritage

Canada has been involved in drug programming for decades. Our first drug legislation appeared in 1908 and efforts by Canadians to deal with the risks of alcohol and drug use have since been waged by governments at all levels, by non-governmental organizations, and by citizen-led community groups.

Mid-term review goals

Although this mid-term review is of an inter-departmental initiative, its goals are, broadly speaking, traditional. The purpose of the mid-term review is to provide information to Canada's Drug Strategy prior to the end of Phase II that either confirms its current design and delivery or indicates the need for changes and ways to bring them about. The issues explored in the mid-term review are different from those of the final evaluation. The mid-term issues are unabashedly about process. It is not until the final evaluation (currently planned for completion in January, 1997) that the effectiveness of Canada's Drug Strategy at reducing the harms caused by problem alcohol and other drug use will be the central interest.

CO-ORDINATION AND THE CDS SECRETARIAT

An assumption underlying the evaluation work already done and that is yet to be done is that co-ordination is definitive of Canada's Drug Strategy. Co-ordination is what will make a set of autonomous alcohol and drug programs a single strategy; without co-ordination, one can have a strategy only in name. It is co-ordination that makes strategies, and it is its performance in especially this area that will determine the success of this experiment in inter-departmental programming. Not all programs can easily be co-ordinated with one another, however, all federal partners can co-ordinate policy development or information management.

Goals Unclear

Although co-ordination was to be a crucial element of Phase I of the Drug Strategy, it was judged weak and was to be strengthened in Phase II. It was for this reason that the government created the Canada's Drug Strategy Secretariat. Although the Memorandum to Cabinet emphasized that the Strategy is to be co-ordinated and gave to the Secretariat the mandate for co-ordination, it contained no explicit or detailed co-ordination goals, and no goals have been developed and agreed upon by Strategy officials since. Equally serious is the absence of clarity over the Drug Strategy Secretariat's roles and responsibilities for co-ordination amongst the federal partners. The result of these general deficiencies is that there is no shared expectation regarding co-ordination amongst Strategy partners.

Harm Reduction

Co-ordination efforts are most successful when there are clear goals

accepted and understood in a similar fashion by the parties involved. It is unclear what role the broad harm reduction goal plays in Canada's Drug Strategy. Harm reduction, in so far as it constitutes the primary goal for the entirety of Canada's Drug Strategy, was introduced for the first time in Phase II. As it is stated in the Memorandum to Cabinet, the goal is vague, referring only to reducing harms to individuals, families, and communities, and there is an explicit call for developing more specific goals that would articulate the concept of harm reduction. The Memorandum to Cabinet left unclear what are the harms to be reduced, by what extent are the harms to be reduced, and by what means. Most importantly, the document does not make it apparent whether and to what extent adopting harm reduction as the central goal for Canada's Drug Strategy marks a difference from Phase I or marks a significant policy shift. This is still the case.

No federal government policy on harm reduction in the drug field exists. One Drug Strategy partner, Health Canada, has developed a "position paper" on harm reduction. This is something less than a formal policy, but is the only available statement within Canada's Drug Strategy of what the term means. No other department has developed a position on harm reduction, and therefore no Strategy-wide position, let alone policy, exists. In other words, for the primary objective of Canada's Drug Strategy there exists no shared understanding of its meaning. Again, that there be agreement about Strategy goals is crucial to effective co-ordination; that there is little sense of a common understanding with regard to the central goal of Canada's Drug Strategy may well be a significant barrier to good co-ordination and is something that Drug Strategy officials should seek to rectify.

The IADPU Experiment

The supply reduction measure of the Integrated Anti-Drug Profiteering Units was introduced to improve the effectiveness of the Proceeds of Crime legislation. The work of these three experimental units is jointly funded and jointly conducted by officials from the RCMP, the Solicitor General Secretariat, Revenue Canada Customs, Justice Canada, and Health Canada.

The IADPUs appear to be succeeding to a significant degree to co-ordinate the actions of the departments involved, and one must ask whether or to what extent they ought to serve as a model for other programming within Canada's Drug Strategy or elsewhere in the range of federal programming. There are a number of reasons why the members of these units appear to be co-ordinating their activities to a

high degree: they share a well-defined goal that is articulated in terms of concrete activity, not abstract generalization; the members of the units are fully aware of what they are expected to do; the co-ordination goals are clearly described; a special body exists to ensure that the necessary co-ordination takes place; the activities of the units are evaluated annually; there is a commitment to the concept of integration by those in charge; and the major partners operate in a quasi-military command and control culture.

That the IADPUs share these characteristics does not imply that they are necessary to successful co-ordination. Not all programs that fall under Canada's Drug Strategy could exhibit this set of characteristics. A command and control culture is rare in the federal government. But this ought not mean that co-ordination is impossible except in such a cultural setting. The other characteristics exhibited by the IADPUs, such as having clear co-ordination goals, seem both more essential to success and possible for other arms of the federal government to attain.

The Secretariat

The Canada's Drug Strategy Secretariat, which was created in 1991, occupies a special place in Canada's Drug Strategy, being the governmental organization with the main responsibility for co-ordination. Given that the Secretariat was a creation of the lead department for Canada's Drug Strategy, it is at least natural from a historical point of view that the central co-ordinating body be housed in Health Canada. One of the constant challenges for the Secretariat, however, has been to have itself regarded as representing Canada's Drug Strategy, not just Health Canada. It would appear, judging from the mid-term reports from the other departments, that the Canada's Drug Strategy Secretariat is often regarded as representing primarily the interests of Health Canada. Despite this general perception from without, however, it would be a mistake to conclude that the Secretariat has restricted itself to representing the interests of Health Canada alone. Paradoxically, within Health Canada, often it is seen as representing mainly interests outside that department. The Secretariat believes that its position as Strategy co-ordinator has been weakened by its being placed within one of the line Branches of Health Canada, a Branch that has a heavy responsibility for programs within the prevention domain of Canada's Drug Strategy. At the time that this report was written, the Secretariat had yet to develop co-ordination goals or to define a clear role for itself, five years after its creation. This has unquestionably hampered the effectiveness with which it has discharged its responsibilities for co-ordination.

Authorities

One reason often offered in explanation is the lack of functional or line authority that the Canada's Drug Strategy Secretariat has to co-ordinate across departments or even within its home department, Health Canada. However, functional authority is neither a necessary nor a sufficient condition for successful co-ordination. What is essential is that Drug Strategy "partners" accept the basic premises that are to bring them together under a single initiative, that all partners accept a set of common goals, have the same understanding of what these goals are and how they are to be accomplished. Again, this is lacking in Canada's Drug Strategy, and, as a result, it remains largely a set of distinct program efforts linked through a single Memorandum to Cabinet.

Moral Authority

The Canada's Drug Strategy Secretariat could play an important role in bringing this sort of understanding and acceptance about through what one might call "moral authority". This is the influence that an organization is able to exercise by virtue of its expertise and the trust and confidence that other organizations and their officials have in it. Neither line nor functional authorities are, strictly speaking, necessary for having considerable moral authority. Taking appropriate action, however, is essential. The Canada's Drug Strategy Secretariat has established working groups and committees through which they could exercise a moral authority to improve co-ordination of Canada's Drug Strategy. The two most important groups in this respect for the Strategy as a whole are the Canada's Drug Strategy Inter-departmental Committee and the Steering Committee. The Canada's Drug Strategy Secretariat can gradually establish the sort of moral authority that will help it to fulfil its mandate to co-ordinate the Drug Strategy. But the Strategy requires a more proactive intervention on the part of the Secretariat and more active involvement by the Inter-departmental Committee and Steering Committee memberships for this potential to be realized.

Accountability

The accountability structures within Canada's Drug Strategy for inter-departmental co-ordination are not clearly defined. At the inception of Phase II, there was literally no organization "in-charge" of Canada's Drug Strategy as a whole. And there was, until late 1994, no committee or other organization within the Strategy with the authority to co-ordinate between departments. Thus, for the greater part of Phase II, it has fallen to the Canada's Drug Strategy Secretariat to attempt to co-ordinate between departments, an unenviable task that it was not well equipped to carry out, especially in an environment lacking a tradition for strong co-ordination.

The Canada's Drug Strategy Secretariat is hampered in fulfilling its mandate for co-ordination, not only by having no line authority, but by the absence of any clear accountability structure for Canada's Drug Strategy as a unity. Aside from the inter-departmental evaluation, there are no accountability provisions for the entire Strategy. Of course, all normal departmental accountability requirements apply to the Strategy, but there is no "inter-departmental accountability" for performance, for meeting Strategy objectives. The Canada's Drug Strategy Secretariat has no role here, except for presenting itself as the "conscience" of the Strategy and encouraging partners to take an inter-departmental, co-ordinated approach to Strategy programming. Again, there is no organization "in charge" of Canada's Drug Strategy as a single program entity. There are rather organizations in charge of only the component parts.

As a result, there is really no sense in which Canada's Drug Strategy is, as a single initiative, responsible for achieving the harm reduction objectives broadly stated in the Memorandum to Cabinet. Each department has its own responsibilities, but there is not a strong sense of shared responsibility and shared accountability for meeting Strategy-wide objectives. Given this, it is not surprising that departmental concerns over-ride strategy concerns. This is a significant problem in the design of inter-departmental initiatives.

CDSS Potential

There is nothing to indicate that the original reasons for establishing the Canada's Drug Strategy Secretariat are no longer valid. Indeed, the experiences of federal multi-departmental initiatives reinforce the idea of establishing special organizations with responsibility for cross-departmental co-ordination, communications, and data development or information management. However, despite the undeniable difficulty of the assignment, it remains disappointing that Canada's Drug Strategy, its Inter-departmental Committee, Health Canada, its lead department, and the Canada's Drug Strategy Secretariat as the organization with the responsibility to co-ordinate, have yet to establish a clear idea of what a co-ordinated Drug Strategy is or should be.

The potential of the Canada's Drug Strategy Secretariat to add value to the Strategy, to increase its cost-effectiveness, is real and has begun to show itself during the past few months, although its potential is not yet fully realized. However, without an organization like the Canada's Drug Strategy Secretariat, it is highly unlikely that the benefits intended by placing the federal government's substance abuse

programs under a single initiative would arise of their own accord. But it is important to note that having an organization is not in itself sufficient. There must be a willingness on the part of the participating departments to have their programs co-ordinated with those of other departments and to have the Secretariat play a role in facilitating this co-ordination. Thus, the responsibility for co-ordination rests with all Drug Strategy partners.

CONCLUSION AND RECOMMENDATIONS

Because the co-ordination of Canada's Drug Strategy amongst the federal partners remains weak:

- **the Canada's Drug Strategy Secretariat should undertake, in collaboration with its federal partners including the central agencies, to establish and bring to fruition specific co-ordination goals that detail which elements of the Strategy are to be co-ordinated and by which organizations. The Secretariat should produce a co-ordination plan for Canada's Drug Strategy and have this plan approved for action by the Inter-Departmental Steering Committee.**

- **One aspect of this plan should be to more clearly define the primary goal of Canada's Drug Strategy, harm reduction, to ensure that there exists a common understanding of this goal amongst federal partners, and to specify how each federal partner will contribute to attaining it.**

- **It is to be understood that the responsibility for co-ordination cannot rest solely with the Canada's Drug Strategy Secretariat. Responsibility must also be accepted by Strategy officials, and by the Steering Committee and the Inter-departmental Committee, which were established to facilitate co-ordination.**

- **The Steering Committee should take responsibility for defining how Canada's Drug Strategy is, as a single program entity, accountable for attaining Strategy-wide objectives, in particular the objective of reducing harm to individuals, families, and communities caused by problem use of alcohol and other drugs.**

TARGETING

The original question concerning the targets of Canada's Drug Strategy was whether the division of funding between prevention, enforcement, and treatment was appropriate. Canada's Drug Strategy, rather than being designed around a single national alcohol and drug policy that is accepted by all program delivery organizations, is instead the result of an evolving historical tradition of programming in Canada, a tradition that has seen demand reduction and supply reduction programs develop at different times and in different organizations. There is no exact science of drug programming that can provide fully certain guidelines for decisions on what type of programs to fund or on what is the most effective combination of programs. Consequently, the question of whether the Canada's Drug Strategy funding scheme is appropriate cannot be answered definitively.

There are 37 federal program areas funded under Canada's Drug Strategy, Phase II. Of these, 21 can be classed as being in the prevention area, 18 as being in the enforcement and control area, and 7 as being involved in treatment. (Some programs function in more than one area.)

Another targeting issue raised in the mid-term review concerns the degree of attention paid to the three major drug groups: alcohol, prescription drugs, and "street" drugs. Alcohol is usually cited as being the drug that causes the greatest damage to the Canadian population. However, the proportion of programs dealing with street drugs would appear to conflict with the priority assigned to them by Canada's Drug Strategy. There are 37 program areas funded by Canada's Drug Strategy (following the breakdown in the Memorandum to Cabinet). Of these, 35 are concerned with street drugs, 18 with alcohol and 13 have some content regarding prescription drugs. (Some programs deal with more than one drug type.)

Target Populations

Phase II of Canada's Drug Strategy is to be more targeted than Phase I to high-risk populations such as out-of-the-mainstream youth, off-reserve aboriginals, seniors, women, and impaired drivers. Canada's Drug Strategy is not alone in delivering programs to people whose health and well-being are at risk. Other federal inter-departmental strategies, such as the Family Violence Initiative and the National AIDS Strategy target high-risk populations. It is often the case that their targeted populations overlap, that it is the very same people who are the targets for different strategies and programs. As programming is now organized in most of these multi-departmental initiatives, it is problems that are the primary targets with attention to sub-populations being secondary. That is, once one has targeted a problem, one then can proceed to target specific sub-populations that suffer from that problem. However, Health Canada has adopted a determinants of health approach that might suggest a targeting primarily of populations, because it is known that certain sub-populations suffer from a wide variety of health problems. There is a significant policy question that can be raised here, but which this study has no mandate to answer. The question is whether interdepartmental strategies should be defined according to problem or according to those sub-populations that suffer, perhaps from multiple problems.

CONCLUSION AND RECOMMENDATIONS

Owing to the appearance of a disparity between the accepted degree of harm caused by alcohol and the comparatively low degree of emphasis on alcohol in federal drug programming:

- **the Canada's Drug Strategy Secretariat in conjunction with the Inter-departmental Steering Committee should undertake a review of Strategy resource allocations in each program area (prevention, treatment, and enforcement and control). This review should attempt to determine what resource levels would be proportionate to the levels of harm caused by each drug group. This should be undertaken as an element to planning federal drug programming following the sunset date for Phase II, March 31, 1997.**

INFORMATION BASE

Appeal to sound information is essential to policy development, program design, program targeting, and co-ordination. Sound information has always been essential to making rational decisions, but, now, its importance also lies in providing services in the most cost-effective manner possible. This interest fits well with the government's current emphasis upon evidence-based decision-making, particularly with regard to macro-level policies, priority-setting, and resource allocation.

Canada's Drug Strategy Secretariat

The Canada's Drug Strategy Secretariat was given a mandate for data development and has initiated projects to develop an alcohol and drug epidemiological data base, to develop a model for assessing the economic costs of drug-related harms, to develop a system for collecting hospital emergency room data, and for co-ordinating drug-related research done in Canada and the United States. Most of these projects involve a number of Drug Strategy partners.

No Plan for Information Management

Despite this work, which should result in data that is valuable for performance measurement and priority-setting, what appears to be missing is a plan that would integrate the production and use of information with the objectives of Canada's Drug Strategy. This problem is a manifestation of the general lack of inter-departmental co-ordination. Without a clear and well-publicized idea of what data are needed, for what, and by whom, the Drug Strategy risks making decisions on the basis of insufficient evidence, or of wasting money producing information that is not needed, that is not used because it is not properly disseminated or properly presented, or by duplicating effort.

It is unclear how it is that Canada's Drug Strategy uses the enormous amount of data and information available in the substance abuse field. There was little evidence that the Drug Strategy was developed using the enforcement data bases maintained by the RCMP, Canada Customs, or Health Canada, or that it took advantage of the information stored at the Canadian Centre on Substance Abuse's clearinghouse. Similarly, little evidence was presented exhibiting how this sort of information is used in designing programs or developing policy.

There exist, however, examples of beneficial information exchange, despite the lack of a Strategy-wide information plan. The shared work concerning off-reserve aboriginals brought about a sensible sharing of information between the RCMP, Solicitor General Canada, and Health

Canada in designing programs for this population. The Integrated Anti-Drug Profiteering Units have improved the sharing of information to improve enforcement practices. And there are fora for information exchange: the interdepartmental committees that meet to exchange information, and the Canadian Centre on Substance Abuse with its drug information clearinghouse, and the Canada's Drug Strategy Secretariat.

CONCLUSION AND RECOMMENDATIONS

Owing to the lack of an inter-departmental plan or system for managing information within Canada's Drug Strategy:

The Canada's Drug Strategy Secretariat should undertake to strengthen the management of information within the Strategy and to this end develop an information management plan, co-ordinated amongst the federal Drug Strategy partners, this plan to ensure that there is:

- **a co-ordinated understanding of what information is needed by Canada's Drug Strategy for developing policy and legislation, for designing and delivering programs;**
- **a co-ordinated plan for producing this information for the Drug Strategy as a whole, not just on a program by program basis;**
- **a way to ensure that the results of data collection and analysis are usable by those who make decisions; and**
- **a way to facilitate the profitable use of this information by those who make decisions.**

This plan should include a schedule of key milestones and clearly indicate which organizations are responsible for carrying out the actions that it specifies. This plan should be approved by the Inter-Departmental Steering Committee for Canada's Drug Strategy.

RESOURCES

Canada's Drug Strategy is a sunsetting initiative. In these times of scarce resources, sunsetting initiatives have become a more popular way to fund programs. In theory, establishing sunsetting programs allows the government to respond to special problems without being committed to long-term expenditures. In the case of Canada's Drug Strategy, Phase I, the government was responding to a perceived unusual severity in alcohol and other drug-related problems in Canada. The Strategy was renewed for a second phase on the grounds that the problem persisted, that the balanced approach the Strategy represented was sound, and that it needed to be given a more focused set of targets for maximum effectiveness.

Strategy organizers must face the possibility, however, of non-renewal and plan for how it will deal with the loss of a substantial influx of funds. The loss of supplementary funds could bring about the collapse of the Strategy, especially the intended element of co-ordination, if it is the case that supplementary funds are a significant motivation for Departments' participation. It is crucial to recognize that the Strategy's benefits are not entirely dependent upon additional funds. Through the other means of program enhancement, it could continue to exist even with a loss of the sunsetting dollars.

RECOMMENDATIONS

In the event that Canada's Drug Strategy is not renewed and its components suffer a complete or partial loss of the funds it provided, Health Canada as the lead department should take it upon itself to ensure, so far as is possible, that the benefits of improved co-ordination, targeting, and the information base are maintained and that an organization be clearly designated with the responsibility to do so. Health Canada should carry out this responsibility in conjunction with its federal partners through the vehicle of the Inter-Departmental Steering Committee.

DRUG-RELATED HARM TO INDIVIDUALS

Canada's Drug Strategy was introduced in 1987 as a special measure to counter a perceived increase in the severity of substance abuse problems in Canada. The 1992 framework document described a range of harms that the Strategy will attempt to reduce. One of these is premature death. This report will present some mortality data from the

years 1987 to 1992, the most recent year for which Statistics Canada data are available. These data do not give reason for optimism and should be of concern to Canada's Drug Strategy officials. However, they are presented primarily as another facet of the Strategy's environment, not as in themselves an indicator of the effectiveness of Canada's Drug Strategy.

DRUG OVERDOSE DEATHS IN CANADA, 1987-1992

Drug type	1987	1988	1989	1990	1991	1992
Opiates	56	55	58	82	133	148
Cocaine	59	80	99	65	92	78
Barbiturates	45	34	34	29	30	29
Alcohol	120	116	112	110	155	178
Tranquilizers	27	20	24	23	17	15

Although these Statistics Canada data indicate a slowly reducing incidence of overdose deaths due to barbiturates and benzodiazepine-based tranquilizers, the trends for the opiates, of which heroin is the most common, cocaine, and alcohol give cause for concern. From the time that the Drug Strategy began in 1987 until 1992, heroin deaths have increased by 265%, cocaine deaths have increased by 32%, and deaths due to alcohol poisoning have increased by 48%. (Note that overdoses account for a small percentage of deaths attributable to alcohol abuse; consider, for example, cirrhoses of the liver, impaired driving, and acts of violence.)

Drug deaths in British Columbia

The data just presented do not tell the worst of it because they do not go beyond 1992. However, the province of British Columbia has experienced a severe escalation of drug overdose deaths since 1992. The numbers from 1993 for British Columbia alone, depicted in the table below, are striking:

This situation is clearly extraordinary and it might not be unreasonable to characterize it as a crisis because the number of overdose deaths far exceeds past patterns. At the time that this report was written,

Drug Type	Deaths
Heroin	298
Cocaine	106
Alcohol	145
Total	549

Canada's Drug Strategy had made no formal Strategy-wide response to the British Columbia situation. Canada's Drug Strategy regards the province of British Columbia as having sole jurisdiction over this situation, at least until the province indicates that federal involvement is appropriate. Accordingly, the Canada's Drug Strategy Secretariat is taking a position of waiting for a clear signal from the province of British Columbia before it reacts. Preliminary discussions between the province and Health Canada have begun regarding the authorization of physicians to offer methadone maintenance treatment, but as of yet no formal changes have taken place. Health Canada has received no specific request for action and has, therefore, not become involved beyond these preliminary discussions.

The federal government has a history of becoming involved with the provinces in crisis situations. It has in recent years responded swiftly and effectively to threats posed by tainted mussels and imported grapes as well as to natural disasters such as the Edmonton tornado. One is immediately led to draw a comparison with the responsiveness of the emergency measures organizations, along with counterpart organizations in other governments, who are charged with the responsibility to take action in the event of certain sorts of emergencies within Canada. One might be excused for expecting there to be an analogous capacity within the drug field where the severity of the harm can be very high.

However, there appears not to exist a plan for the federal government to respond to drug-related emergencies, either on its own or in concert with the provinces. Further, as noted earlier in this report, with the disbanding of the Federal-Provincial Advisory Committee on Alcohol and Other Drug Problems, there no longer exists an organization with

a clear responsibility for federal-provincial co-ordination on drug issues, including extraordinary or emergency situations. The situation in British Columbia poses a challenge to the Canada's Drug Strategy partnership, one piece of which is to be federal-provincial, to take joint action in extraordinary situations.

Although they are not confined to Vancouver, most of the overdose deaths have occurred in that city. Therefore, the problem is confined to a relatively small area and could become a good test case for the federal harm reduction approach in the drug field, should the federal government be asked to become more involved. The British Columbia situation is one where a harm reduction approach to substance abuse should have something to offer. It must be noted, however, that Vancouver is not the only city with recently elevated overdose death levels. Toronto and Montreal have also experienced increases, albeit, not to the same extent. Without either a plan or an organizational capacity, it would appear that the federal-provincial partnership has work to do to define what a harm reduction approach to substance abuse involves and implies for federal government and joint federal-provincial action in extraordinary situations.

CONCLUSION AND RECOMMENDATION

Owing to the unusually high number of drug overdose deaths in recent years and the lack of a Strategy-wide harm reduction response to this fact:

- **Health Canada Drug Strategy officials should work in concert with the Interdepartmental Steering Committee, the Canada's Drug Strategy Interdepartmental Committee, and representatives from provincial/territorial and municipal governments to develop a co-ordinated plan of action for responding to situations involving unusually high levels of drug-related harm such as this profusion of overdose deaths in a short period of time.**

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Health Canada

evaluation chronology

June, 1993	Baseline data collection complete, discussion paper submitted to CDSS
June, 1994	Terms of Reference drafted for mid-term review
June, 1994	Data collection begins
November, 1994	Reports from departments begin to be delivered to Program Evaluation Division, Health Canada
June, 1995	Health Canada mid-term review report completed
October, 1995	Inter-departmental report submitted to Audit and Evaluation Committee, Health Canada
November, 1995	Inter-departmental report submitted to Evaluation Working Group
February, 1996	Report approved by Audit and Evaluation Committee, Health Canada
May, 1996	Report submitted to Interdepartmental Steering Committee
November, 1996	Report approved by Interdepartmental Steering Committee

credits

This project was conducted by the Inter-departmental Evaluation Working Group for Canada's Drug Strategy. The Working Group members were Hassan Baage (Revenue Canada, Customs and Excise), Judy Berger (Human Resources Development Canada), David Chaikoff (Treasury Board Secretariat), Pete Conley (Canada's Drug Strategy Secretariat), Neil Ewert (RCMP), Nick Falcon (Justice Canada), Gord Farrell (Correctional Service Canada), Doug Macdonald (Department of Foreign Affairs and International Trade), Wayne McNulty and Nancy Brady (Canadian Heritage), Chris Walker (Solicitor General Canada), and the Chair was Howard Duncan of the Evaluation Group of Health Canada.

The Canada's Drug Strategy Secretariat provided advice and organizational support.

The Inter-departmental Program Working Group also provided advice. Its members were program officials from each department participating in Canada's Drug Strategy.

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chapter one
background

What is Canada's Drug Strategy?

Canada's Drug Strategy is a five year inter-departmental initiative intended to improve the effectiveness of Canada's psychoactive drug programming. A predecessor initiative, the National Drug Strategy, began in 1987 and expired in March, 1992. Canada's Drug Strategy is a renewal and modest modification of the original National Drug Strategy and is often referred to as Phase II of Canada's Drug Strategy.

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Canada has been involved in drug programming for decades. Our first drug legislation appeared in 1908 and efforts by Canadians to deal with the risks of alcohol and drug use have since been waged by governments at all levels, by non-governmental organizations, and by citizen-led community groups.

Federal role

Jurisdiction over the myriad alcohol and other drug interventions is shared between the federal and the provincial/territorial governments. In broad terms, the federal government is responsible for:

- legislation: the Narcotic Control Act and the Food and Drugs Act and their regulations, and the Criminal Code. All levels of government enforce the different parts of this legislation.
- policing within Canada, at the borders, and internationally.
- federal penitentiaries.
- alcohol and drug programming for status Indians on reserve.
- financial support to the provinces for alcohol and drug programming.
- international drug programming, including that conducted under the auspices of the United Nations and its agencies and the Organization of American States.

In addition to these responsibilities, the federal government delivers discretionary alcohol and drug programming in the field of prevention (awareness programs, education programs, community support programs, employee assistance programs, and so on).

Provincial role

The provinces and territories of Canada also have major roles to play in alcohol and drug programming, partly owing to the division of powers in the Constitution Act that gives to the provinces jurisdiction over most health and education matters. Therefore, in so far as alcohol and drug issues are health and education issues, many are dealt with by provincial governments.

For example, provinces deliver:

- hospital services that include treating individuals suffering from alcohol or drug-induced disorders.
- special addictions treatment centres.
- in-school awareness and prevention programs.

In addition to this sort of programming, the provinces have the main responsibility for legislation and regulations governing alcohol. They also regulate the medical and pharmaceutical professions and work with the federal government in preventing and dealing with the abuse of prescription psychoactive drugs.

A single system

Underlying the development of the Drug Strategy is the idea of taking fullest advantage of these efforts by assembling a single co-ordinated system from the separate federal programs, enhancing selected areas, and developing partnerships or otherwise working with other organizations in a more co-ordinated fashion. Canada's Drug Strategy is, then, to be a **comprehensive** inter-Departmental federal initiative to enhance and co-ordinate alcohol and drug programming in the three traditional program areas: prevention, treatment and rehabilitation, and enforcement and control.

This broad design is common to both Phase I and Phase II. However, Phase II does differ in a number of ways from its predecessor. The Strategy Against Driving While Impaired is now part of Canada's Drug Strategy, whereas it was a separate initiative before 1992; there have been a number of changes in target populations; and more attention is being paid to enforcement initiatives, especially to implementing the Proceeds of Crime legislation. Canada's Drug Strategy, Phase II differs from the original in response to such perceived changes in the drug field as:

- Canada has become more of a transit way for illegal drug shipments;
- Proceeds of Crime legislation is now in place and requires special resources for taking fullest advantage of it; and
- the provinces have become heavily involved in prevention programming for the mainstream population, making it possible for the federal government to concentrate on high-risk sub-populations.

Phase II is intended to place more emphasis in prevention programming upon such high-risk or otherwise non-mainstream groups as street kids, dropouts, off-reserve aboriginals, the unemployed, seniors, women, and dysfunctional families. This short list, taken from the Memorandum to Cabinet, is but a list of examples. It is to the judgement of the Departments participating in the Strategy's prevention programs which specific risk groups to target. The main conceptual shift, however, is from targeting the population in general, most of whom are not at risk of suffering from drug-related problems, to targeting specifically those who are at a high-risk of having these problems. In the parlance of the drug field, this change marks a shift in emphasis from primary prevention to secondary prevention. (Treatment is sometimes called tertiary prevention.)

In general, however, Phase II of Canada's Drug Strategy is very similar to Phase I. Most of the changes are adjustments. In Phase II, the Strategy remains a comprehensive inter-Departmental federal initiative to enhance and co-ordinate alcohol and drug programming in prevention, treatment, and enforcement and control. The financial supports that it brings to existing programming have, at least in design, undergone a minor shift in focus. In Phase I, monies for demand reduction comprised 70% of the Strategy's intended outlay; in Phase II, according to the Memorandum to Cabinet, only 60% of the funding goes to demand reduction.

Funding

Cabinet approved the following funding under the renewal of Canada's Drug Strategy:

- renewal funding of $25.9 million per year, some of which would be redirected to new priorities for a five year total of $129.5 million.
- incremental funding of $8.1 million per year for implementing the Proceeds of Crime legislation, to provide federal employee assistance programming, and to maintain the Canadian Centre on Substance Abuse for a five year total of $40.5 million.
- $20.0 million for ongoing funding of federal-provincial alcohol and drug treatment and rehabilitation programming and of RCMP drug programming for a five year total of $100.0 million.

If one takes into account the ongoing funding, Canada's Drug Strategy is a $270.0 million five year initiative. However, recent years have witnessed the effects of the heightened concern over the federal debt

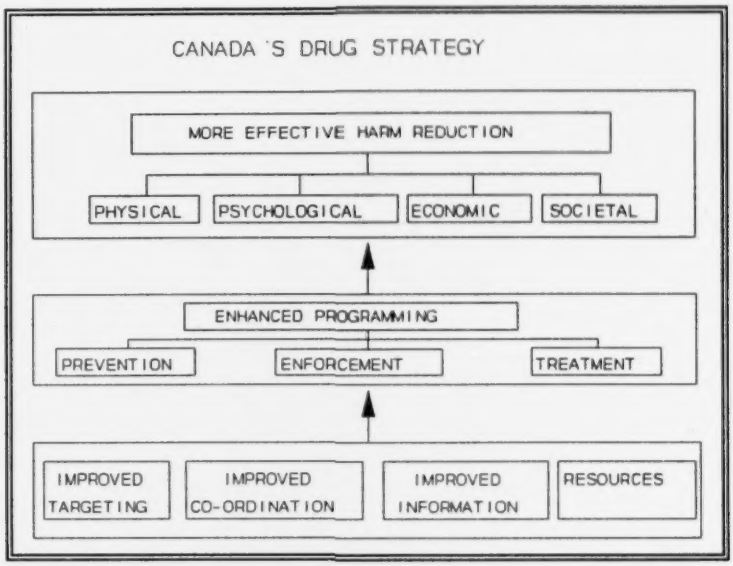
and annual deficit. Departments have had their budgets cut a number of times since Phase II of the Strategy began. One of the goals of the mid-term reviews for each participating department was to learn whether these cuts affected the level of resources to be received through the Strategy. The reason for this is straightforward. It would be misleading and possibly unfair to assess a program on the assumption that it received supplementary income according to the original Treasury Board decision when in fact it received less or had its ongoing funding reduced. Specific figures on budget cuts can be found in the individual reports from each department.

Canada's Drug Strategy objectives

The Memorandum to Cabinet made it plain that, in 1992, the task of setting specific Strategy goals remained to be completed. An evaluation can be relevant to a program only if it makes assessments concerning the program's objectives. Therefore, establishing clear objectives for the Strategy became the first task in producing an evaluation framework. The Evaluation Working Group in consultation with the Program Working Group (see p. 13 for some details) established three orders of objective for Canada's Drug Strategy: improved harm reduction, enhanced programming, and putting in place the mechanisms of enhancement, namely, improved targeting, co-ordination, information, and resources. (See chart on the next page.) This approach to Strategy objectives is grounded in the Memorandum to Cabinet, the Treasury Board submissions, and discussions with the Canada's Drug Strategy Secretariat. It represents a reconstruction of the ideas contained in these documents and is intended to display the logical structure of the overall Strategy.

The Memorandum to Cabinet states that the objective of Canada's Drug Strategy is to reduce the harm to individuals, families, and communities caused by problem alcohol and other drug use. The other orders of objective are related to this basic objective as means to end. Accordingly, Canada's Drug Strategy intends to make harm reduction activities more effective by enhancing existing programming. And programming will be enhanced primarily in four ways: by improving targeting, co-ordination, information, and resources.

There is an important implication in setting up the orders of objective in this way. Note that supplementary resources are portrayed as on a par with the other means for enhancing programs. The implication of this, felt especially in times of fiscal restraint, is that a diminution of one of these means is to be compensated for through the others.



Therefore, if Canada's Drug Strategy or parts of it suffer from a budget cut, the response ought to be an appeal to the others, to yet better co-ordination, more effective targeting, and better information and use thereof.

Evaluation requirements

The decision by Cabinet to renew funding for Canada's Drug Strategy was accompanied by a requirement for its evaluation. The Treasury Board decisions (one for each department participating in the Drug Strategy) specified that there be three evaluation products:

- an evaluation framework submitted by December 1, 1992,
- a mid-term review submitted by March 1, 1995, and
- a final evaluation submitted by January 1, 1997.

Each of these is to be produced in two forms, one for the Drug Strategy as a whole, the other for the components of each participating Department. For each of the framework, mid-term review, and final evaluation, then, there will be a strategy-wide document and documents for each of the participating Departments' components.

This evaluative work was intended to be co-ordinated to achieve greater cost-effectiveness. Achieving co-ordination has involved and will continue to involve the work of three committees which were established for the purposes of the evaluation work.

- Inter-Departmental Evaluation Working Group
- Inter-Departmental Program Working Group
- Inter-Departmental Steering Committee

The Inter-Departmental Evaluation Working Group is chaired by a representative of the Program Evaluation Division of Health Canada. The other members represent the evaluation units of the participating departments and the Treasury Board Secretariat; a representative of the Canada's Drug Strategy Secretariat sits as an observer. This committee is responsible for producing the evaluation products for the Treasury Board and, more importantly, for co-ordinating evaluation designs and data collection and sharing the results of analysis.

The Inter-Departmental Program Working Group is chaired by a representative of the Canada's Drug Strategy Secretariat. Other members are representatives of the organizations that deliver programs supported by the Drug Strategy; the chair of the Evaluation Working Group sits as an observer. Its role is to provide co-ordinated information and advice to the Evaluation Working Group.

The Inter-Departmental Steering Committee is composed of the Assistant Deputy Ministers of the participating department branches and is chaired by the Assistant Deputy Minister, Health Promotion and Programs Branch, Health Canada. Its responsibility was originally to review and approve the design of the evaluation, to ensure that it meets the needs of the participating departments, and to approve the reports that are generated. It has since had its mandate broadened to include co-ordination of the Strategy itself; more will be said of this committee later in the report.

Mid-term review goals

Although this mid-term review is of an inter-departmental initiative, its goals are, broadly speaking, traditional. The purpose of the mid-term review is to provide information to Canada's Drug Strategy prior to the end of Phase II that either confirms its current design and delivery or indicates the need for changes and ways to bring them about.

Main Issues

The issues explored in the mid-term review are different from those of the final evaluation. The mid-term issues are unabashedly about process. It is not until the final evaluation that the effectiveness of Canada's Drug Strategy at reducing the harms caused by problem alcohol and other drug abuse will be the central interest. There are a

number of reasons for this decision to restrict the present study to issues that would normally be of secondary interest.

Most important of these reasons is that Canada's Drug Strategy is itself largely a process initiative. Again, most of its individual programs have a longer history than it does. The major exception are the prevention programs concerning drugs other than alcohol; these were re-introduced in Phase I after a lengthy period during which the federal government concentrated on supply reduction measures for these drugs. Apart from injecting supplementary funds, Canada's Drug Strategy is to introduce an element of co-ordination to bind the heretofore disparate array of programs in the drug field into a single and comprehensive venture. Phase II was intended to be more specifically targeted and to be given a stronger information base.

In a straightforward sense, to assess Canada's Drug Strategy is to assess the extent to which specific processes have been introduced and whether they have had their intended effects on the component programs. The Strategy's design assumes that greater effectiveness in harm reduction will be realized as a direct result of co-ordinating existing efforts, targeting them in more sophisticated ways, providing them with an improved information base, as well as supplementing their resources. If the evaluation works within these assumptions, then it would follow that poor co-ordination, poor information development and use, poor targeting, and a loss of additional funds would reduce the effectiveness of the Strategy from what was expected of it. Therefore, even though this review does not directly broach effectiveness issues, its findings on these matters of process could be taken to indicate whether its effectiveness has improved.

Deferring the issue of the effectiveness of Canada's Drug Strategy in reducing drug-related harm until the final evaluation will allow more time for evidence of its effectiveness to accumulate. Data on, for example, drug-related mortality at the time that this report was written, were available only up to 1992, the first year of Phase II. Assessing effectiveness now would be extremely difficult; the data to do so are, for the most part, simply not yet available. There was agreement amongst the members of the Evaluation Working Group, the Program Working Group, the Steering Committee, the Canada's Drug Strategy Secretariat and the Treasury Board Secretariat to wait until the final evaluation to attempt a direct assessment of effectiveness.

The point to bear in mind, however, is that the mid-term review is not looking at these issues of process simply as an alternative to what some might see as the more valuable effectiveness questions. Quite the contrary, these issues of process are crucial to the design of Canada's Drug Strategy. Its objective of improving the government's harm reduction efforts are to be realized by putting these processes in place. At this point in the life of the Strategy, issues of process are the most important to consider.

The primary focus will be on the third order objectives, the mechanisms for program enhancement: improved targeting, co-ordination, information, and resources. The questions will be the same as for the final evaluation:

Targeting:

- Is the division of funding between prevention, enforcement and control, and treatment appropriate to Canada's problems with alcohol and drugs?

Co-ordination:

- Does the Canada's Drug Strategy Secretariat have sufficient resources and a sufficiently clear and strong mandate to achieve its objectives?
- Are there effective mechanisms for co-ordinating the various federal drug policies or for co-ordinating federal policies with those of other governments or other Strategy partners?
- Are there effective mechanisms for co-ordinating programming between federal departments and between federal departments and other levels of government and Strategy partners?
- Is the Canadian Centre on Substance Abuse an effective co-ordinating mechanism for Canadian drug programming? (This will be addressed through the report of the evaluation of the Centre conducted by the Program Evaluation Division, Health Canada, and submitted to Parliament in June, 1994.)

Information:

- What information is now used to develop federal policies and programs in the drug field? Has Canada's Drug Strategy made for improvements in this information base? If so, how has this new information been used in policy and programming decisions?

Resources:

- Have the resources approved by Cabinet for Canada's Drug Strategy been made available to their intended recipients?
- Have the resources made available actually been used for their intended purposes?
- Have the resources been appropriate to the objectives of the Strategy?

It is not to be expected that full answers will be available to each of these questions. Not enough time will have passed for all of the Phase II changes to display their effects. However, the review has been able to determine whether the intended actions of Phase II are under way, whether intended improvements in targeting have been made, whether the intended degree of co-ordination and co-operation has come about, whether developments in the information base are becoming evident, and whether programs have received their anticipated resources improvements and are using them as Canada's Drug Strategy intended.

Departmental Participation in the Review

Through the Interdepartmental Evaluation Working Group, the evaluators from each department participating in Canada's Drug Strategy developed a single plan for evaluating not only the entirety of the Strategy, but that would form the core of any evaluative work done in the individual departments. Therefore, although department-specific studies could cover any additional issues, each such study shared a core set of issues and questions. The hope was to provide a means for more easily comparing the results from each department and synthesizing them for the purposes of the report of the Strategy overall.

The Reports

This report is of Canada's Drug Strategy, seen as a single inter-departmental program. Attached as appendices are mid-term review reports of the contributions of each participating department. The

issues covered in these latter reports are similar in that they include targeting, co-ordination, information, and resources, but the specific questions differ. The questions can most easily be compared by referring to the 1992 Evaluation Framework, also attached as Appendix A. To a certain extent, the information in this inter-departmental report is dependant upon that contained in the departmental accounts. However, this report is not a summary of the departmental studies; the reader should not expect to find all of the departmental information presented here in capsule form and is encouraged to read these separate reports. For example, detailed information on program targets and resources is available only in the departmental reports.

Each department's mid-term reports were developed along common themes in order to be useful to the inter-departmental report. However, responsibility for the views expressed or the recommendations made in these reports rests solely with the source departments. Therefore, even though they appear here as appendices under a Health Canada cover, it is not to be thereby understood that the departmental reports represent Health Canada's views, except for the report on Health Canada's contributions to the Drug Strategy. Only the source department is responsible for the contents of the individual reports.

chapter 2
co-ordination and the Canada's Drug Strategy Secretariat

BACKGROUND

Canada's Drug Strategy is, in intention, a co-ordinated multi-departmental initiative. To a significant extent, this initiative is an experiment in the management of federal interventions, involving as it does a linkage of alcohol and drug programs from seven departments and, in some cases, from many branches of single departments. The underlying assumption is that certain benefits will accrue from relating these programs under a single "strategy", benefits that would otherwise not present themselves. These benefits are to result from not only the additional resources furnished by the Strategy, but, more importantly from the point of view of how the government manages its programs, from co-ordinating its various components.

An assumption underlying the evaluation work already done and that is yet to be done is that co-ordination is definitive of Canada's Drug Strategy. Co-ordination is what will make a set of autonomous alcohol and drug programs a single strategy; without co-ordination, one can have a strategy only in name. Adding resources to programs does not in itself make the result a strategy, even if the resources are approved under a single Memorandum to Cabinet. Similarity of target does not in itself make a set of programs a single strategy. And having better information for policy and programming decisions does not make a set of programs a strategy. It is co-ordination that makes strategies, and it is its performance in especially this area that will determine the success of this experiment in inter-departmental programming.

Governments have long recognized the value inherent in co-ordinating programs and in forming partnerships where this is appropriate. This recognition has become much more acute as they seek to reduce deficits; these days, partnerships and co-ordinated programming are more often seen as avenues to maintaining acceptable levels of service to the public while controlling costs. That the third order objectives of the Drug Strategy present resources as on a par with co-ordination

suggests just this point, that programming can be improved without spending more money. Co-ordination is generally thought to contribute such benefits as improved effectiveness, greater efficiencies, reduced duplications, greater cost-effectiveness, and many positive spin-off effects from the working together of people and organizations.

Co-ordination, then, is a means to an end, a means to more effective programs. In general, this mid-term review will try to learn how well these means are functioning in themselves; the final evaluation will try to ascertain their effects on the lives of Canadians. The present concern for fiscal restraint only emphasizes the appropriateness of this point of departure for the study.

No standards

Assessing whether the Drug Strategy is performing well in this regard depends on just what one expects, for the terms 'co-ordination' and 'partnership' are ambiguous. We need, therefore, to specify their meaning for the purposes of this review, to specify their meaning in ways that delineate reasonable expectations of performance for those involved in Canada's Drug Strategy. One way to answer this question would be to appeal to what the government expected of the Strategy. Unfortunately, pursuing this avenue does not provide us with guidelines. There simply was no detailed concept of co-ordination developed for a specific application to Canada's Drug Strategy. There exist no agreed upon standards in the government of Canada for measuring performance with regard to partnerships or co-ordination. Nor do there exist clear descriptions in the Memorandum to Cabinet or Treasury Board decisions of what was expected of Canada's Drug Strategy's co-ordination effort. Accordingly, it is difficult for this review to judge unequivocally whether the Drug Strategy is successful in this matter. However, the report can draw comparative conclusions and indicate where opportunities for stronger co-ordination lie and what benefits might be expected from taking advantage of them.

Ambiguous Concept

Co-ordination is an ambiguous term and can refer to many different states of affairs, from the mere absence of conflict between programs or policies to a full partnership where a program is jointly funded, administered and delivered to the public. The literature in the field indicates a wide range of possible meanings. Consider the concept of partnership. Canada's Drug Strategy is not formally a partnership although its promotional and descriptive literature often describes the various participants as partners; nevertheless, it is helpful for articulating the concept of co-ordination to look at partnership in its range of meanings.

A number of different taxonomies of partnerships appear in the literature. One works in the following way, with the stronger senses appearing first:

- **Collaborative partnerships** involve a sharing of decision-making power, of resources, and of risk. Each partner gives up some autonomy.

- **Operational partnerships** share work and resources, but not necessarily decision-making authority. However, as with collaborative partnerships, there must exist a strong measure of co-ordination if the work and resources are to be shared effectively.

- **Contributory partnerships** share resources only; they are more like sponsorships.

- **Consultative partnerships** are those in which one partner solicits information or advice from the other(s) in order to better develop programs and policies.[1] (the endnotes are found on page 69)

The latter two are very weak senses of partnership. One is tempted to regard these uses of the term as hyperbolic, for one is calling partners all those people or organizations who receive public funds or with whom government consults. Consequently, the first two notions are more instructive for developing a sense of co-ordination that is appropriate for Canada's Drug Strategy. At the core of this concept is that of sharing, and partnerships can be described as stronger or weaker, tighter or looser, according to what it is that the participants share, be it power, authority, resources, work, information, responsibility, or risk. The point of a partnership, and this is key to co-ordination, too, is to achieve jointly-held goals in a more effective or cost-effective fashion than is possible by acting alone.

A Sample of Indicators

The concept of 'co-ordination', too, has many senses, some stronger than others, some differing from others according to what is being co-ordinated. Of most interest to this report is the extent of co-ordination displayed by the actual activities undertaken by Canada's Drug Strategy. Co-ordination could be indicated by such things as:

- a common understanding and acceptance of the objectives of Canada's Drug Strategy by the participating departments;

- a clearly defined and commonly accepted set of co-ordination goals for Canada's Drug Strategy;
- a policy framework under which are systematically located the diversity of alcohol and other drug programs;
- a strong organizational mechanism for co-ordinating planning, policy, and program delivery;
- formal agreements, such as Memoranda of Understanding, between organizations
- active working committees with decision-making authority
- active steering committees with decision-making authority
- a strong system of information flow to ensure rational, evidence-based planning, policy development, and program delivery;
- a capacity to mobilize and take fullest advantage of the skills of the participating departments in dealing with Canada's alcohol and other drug problems;
- sharing costs and responsibilities between responsibility centres; and
- a joint capacity to deal with emerging issues or dramatic changes in the nature of Canada's drug problems.

Some of these indicators are stronger than others; this mirrors the fact that the concept of co-ordination is ambiguous. All reflect the core ideas expressed in the concepts of collaborative and operational partnerships. Just what is an acceptable degree of co-ordination among the participants in Canada's Drug Strategy cannot be answered unequivocally by this review because there are no agreed upon standards to which it can appeal. It can be hoped, however, that the review will bring it about that co-ordination goals and standards appropriate to the Strategy are developed by its officials.

Expectations of co-ordination

There would appear to be some departments and programs that have greater affinities and therefore greater potential for co-ordination than others. If one considers the co-ordination of program activities, there would appear to be little potential, for example, for Sport Canada to co-ordinate its program operations with those of the Department of Foreign Affairs and International Trade. On the other hand, there are considerable affinities amongst the departments involved in law enforcement, and the Integrated Anti-Drug Profiteering Units are the result. Therefore, the potential for co-ordinating program activities appears to be varied across Canada's Drug Strategy. However, one would expect the potential for co-ordinated policy development,

information production and exchange, and strategic planning to be much more widespread.

It should be stated that the mid-term review heard the view expressed that one should not expect more by way of co-ordination than that the programs covered by the Memorandum to Cabinet are actually being carried out and that they do not conflict with one another. The assumption here is that the Memorandum to Cabinet was drafted in such a way that if the programs are actually carried out as planned, the result will be co-ordinated, that there is no need for more overt expressions of co-ordination. This opinion is not without interest. A Memorandum to Cabinet that proposes a coherent system of programs should well result in a co-ordinated system of programs, at least in the sense that they do not conflict with one another or reduce each other's effectiveness. This weak sense of co-ordination, however, should be a normal part of government business, but not the special objective of an initiative like Canada's Drug Strategy. Something stronger is wanted by co-ordination in the Drug Strategy than routine sound management of government. Indeed, the Memorandum to Cabinet explicitly calls for stronger co-ordination. It is for these reasons that the mid-term review appealed to stronger indicators than the absence of conflict between programs.

A Minimum: Shared Goals

Co-ordination efforts are most successful when there are clear goals accepted and understood in a similar fashion by the parties involved. This applies in two senses here, with regard to the goals of Canada's Drug Strategy and with regard specifically to its co-ordination goals. Mid-term reviews and evaluations of government programs usually try to learn if a program is achieving its objectives. Normally it takes a certain amount of work by evaluators and program officials to establish with clarity and precision what are a program's objectives. This is work worth the doing, however, as it would be unproductive, not to mention unfair to assess a program against objectives other than its own. This work was especially difficult in the case of the Drug Strategy, a fact that in itself is an indicator of the degree of cohesiveness within the Strategy at the time.

The Inter-departmental Evaluation Working Group met in mid-1992 with a committee of officials of Canada's Drug Strategy, the Inter-departmental Program Working Group, to learn what were the objectives against which to evaluate its performance. This first experience of the evaluation team was revealing of how far the Program Working Group had come in cultivating a sense of common

purpose, of a common understanding in its mission, of being partners in a shared enterprise. These first experiences were of a group easily able to represent the interests and purposes of the programs its members were directly involved in delivering, but less able to speak as members of the same team.

What is noteworthy is that the Program Working Group had a difficult time coming to grips with the notion of strategy-wide objectives at all, let alone with specifying what they were. In other words, there seemed to be little sense of common purpose or common understanding among the members of this committee. Further, the Canada's Drug Strategy Secretariat experienced the same sort of difficulty in articulating Strategy-wide goals as the others. At that time, the only stated objective was that described in the Memorandum to Cabinet of reducing the harm to individuals, families, and communities caused by problem use of alcohol and other drugs. The Secretariat seemed at times out of place, left with a role as moderator in a discussion group. In the end, the evaluators were asked to propose a set of Strategy-wide objectives. The Program Working Group accepted the proposal as presented earlier on page 11. It remains unclear whether these goals are actually used by the Strategy to ground co-ordinated activity in the drug field.

The reason for the lack of a sense of common purpose appeared simply to be the fact that the members of the Working Group were not accustomed to thinking of their roles in the context of a single strategy, as parts of a system of programs all intended to meet a shared goal. Further, the harm reduction goal, as discussed below, was new with Phase II and had not been fully integrated into the thinking of all departments. As a result, the Strategy seemed, for the most part, a set of individual and autonomous programs linked only by a common Memorandum to Cabinet.

Harm Reduction: an important example

It is unclear what role the broad harm reduction goal plays in Canada's Drug Strategy. Again, harm reduction, in so far as it constitutes the primary goal for the entirety of Canada's Drug Strategy and for federal psychoactive drug programming in general, was introduced for the first time in Phase II. Harm reduction appears in the 1992 Memorandum to Cabinet as the broad goal of the renewed Drug Strategy. As it is stated in this document, the goal is vague and there is an explicit call for developing more specific goals that would articulate the concept of harm reduction. The Memorandum to Cabinet left unclear what are the harms to be reduced, by what extent are the

harms to be reduced, and by what means? Most importantly, the document does not make it apparent whether and to what extent adopting harm reduction as the central goal for Canada's Drug Strategy marks a difference from Phase I or marks a significant policy shift. This is still the case.

The concept of harm reduction and its role in Canada's Drug Strategy and federal drug programming and policy has been of controversy during Phase II. It is a concept discussed in the academic world, by special interest groups, by public health groups, and discussed with many different meanings. For some involved in the discussions, harm reduction has taken on a strong political connotation and is often presented as an alternative to the legislative framework of controls on psychoactive drugs that is enforced in Canada and around the world, and that is described in the United Nations conventions on these drugs. Consequently, the concept of harm reduction has come to mean, for some people, the decriminalization or legalization of some or all psychoactive drugs.

It is safe to say that this is not the position of the federal government or of Canada's Drug Strategy officials, but it is still unclear what Canada's Drug Strategy intends by this concept. It is still unclear what difference this broad goal was to have made or actually has made to Drug Strategy programming in general. For most of the demand reduction programs at Health Canada, there is a fit between harm reduction and the shift in targets from the general population to high risk sub-populations. The point is that these programs now pay more attention to those most likely to suffer from drug-related harms rather than to the general population. Put another way, these programs no longer have as their main goal to prevent non-users from becoming users or abusers. Abstinence is no longer the object of the exercise; rather, reducing the harms experienced by high risk groups is the object. There is, then, a sense in which the concept has made a difference to these programs in this department. But it is not evident what difference the concept of harm reduction was to have made to other Drug Strategy programs.

No federal government policy on harm reduction in the drug field exists. Health Canada has developed a "position paper" on harm reduction. This is something less than a formal policy, but is the only available statement within Canada's Drug Strategy of what the term means. The full paper is reproduced as an appendix to this report, but one of its key paragraphs is the following:

> Health Canada supports the broad interpretation of "harm reduction" within a supply control/demand reduction paradigm to include the prevention of use by non-users (abstinence), the management of risk of harm (for users and others), and the treatment of individuals either directly or indirectly affected by use. Within this broad continuum, Health Canada recognizes and accepts, but does not condone, that some people will use and abuse drugs.

This position certainly distances the department from those who interpret 'harm reduction' as implying decriminalization, but it does little to help those who want to understand to what extent the adoption of harm reduction as a goal for the Drug Strategy is to make a difference to programming. No other department has developed a position on harm reduction, and therefore no Strategy-wide position, let alone policy, exists. In other words, for the primary objective of Canada's Drug Strategy there exists no shared understanding of its meaning. It must be concluded then, that in no significant sense is there a shared acceptance of harm reduction as the central goal amongst Drug Strategy partners. For this goal to be meaningfully shared, it must be similarly understood, and there is little evidence of a shared understanding of this goal beyond that found within some programs, such as some concerning out-of-the-mainstream youth, that explicitly emphasize harm reduction. It is not clear that harm reduction is of much importance or has made a difference to many Drug Strategy programs, especially the law enforcement programs. Again, that there be agreement about Strategy goals is crucial to effective co-ordination; that there is little sense of a common understanding with regard to the central goal of Canada's Drug Strategy may well be a significant barrier to good co-ordination and is something that Drug Strategy officials should seek to rectify.

Designing in co-ordination: the IADPU Experiment

Discussions with officials involved in preparing the Memorandum to Cabinet and from the central agencies suggested that what was expected of Canada's Drug Strategy was something more than the mere absence of conflict and a reduction of duplication, but something less than a full collaborative partnership with joint program delivery across all federal departments. It is clear from the Memorandum to Cabinet that a high degree of autonomy was built into each department's programs. There is one notable exception to this, the supply reduction measure of the Integrated Anti-Drug Profiteering Units, which were introduced to improve the effectiveness of the Proceeds of Crime legislation. The work of these three experimental

units is jointly funded and jointly conducted by officials from the RCMP, the Solicitor General Secretariat, Revenue Canada Customs, Justice Canada, and Health Canada. It is described fully in the mid-term review report from the Solicitor General Canada. The degree of integration here is not to be expected of Canada's Drug Strategy as a whole, nor was it intended by its designers.

The IADPUs appear to be succeeding to a significant degree to co-ordinate the actions of the departments involved, and one must ask whether or to what extent they ought to serve as a model for other programming within Canada's Drug Strategy or elsewhere in the range of federal programming. There are a number of reasons why the members of these units appear to be co-ordinating their activities to a high degree:

- they share a well-defined goal that is articulated in terms of concrete activity, not abstract generalization;
- the members of the units are fully aware of what they are expected to do; the co-ordination goals are clearly described;
- a special body exists to ensure that the necessary co-ordination takes place;
- the activities of the units are evaluated annually;
- there is a commitment to the concept of integration by those in charge; and
- the major partners operate in a quasi-military command and control culture.

That the IADPUs share these characteristics does not imply that they are necessary to successful co-ordination. Not all programs that fall under Canada's Drug Strategy could exhibit this set of characteristics. A command and control culture is rare in the federal government. But this ought not mean that co-ordination is impossible except in such a cultural setting. Such a culture may speed the process of co-ordinating activities, but it hardly seems essential. The other characteristics exhibited by the IADPUs seem both more essential to success and possible for other arms of the federal government to attain.

Difficult Challenge

One cannot emphasize enough the necessity of having shared goals if meaningful co-ordination is to occur. Co-ordination can be established best if there is a shared understanding of what is to be co-ordinated. And it must be said that co-ordination will remain limited until Canada's Drug Strategy articulates just what it intends to do by way of co-ordination. No one expects the Drug Strategy as a whole to be co-

ordinated in the same way and to the same extent that the IADPUs are, but, it would appear that the government expects more than an absence of conflict. From one perspective, this is an opportunity for creative joint programming and policy development, but from another point of view, this is an extremely difficult challenge, a situation that might easily lead to the most conservative of co-ordination efforts.

To date, no specific co-ordination goals exist. Whether or not the Drug Strategy as a whole is as co-ordinated as the government intended, it is certain that in the absence of specific co-ordination goals, it is not as well co-ordinated as it might be. It follows that the benefits of this experiment in co-ordinated government programming are not being fully realized.

THE CANADA'S DRUG STRATEGY SECRETARIAT:

Mandate and responsibilities

The Canada's Drug Strategy Secretariat, which was created in 1991, occupies a special place in Canada's Drug Strategy, being the governmental organization with the responsibility for co-ordination. The Deputy Minister of National Health and Welfare created the Canada's Drug Strategy Secretariat mainly for the purpose of preparing for the Phase II renewal. However, given that co-ordination was considered to be lacking in Phase I, the Memorandum to Cabinet recommended that the Secretariat continue its existence beyond the completion of the renewal process and provide a central co-ordinating function for the Strategy, among other things. The Canadian Centre on Substance Abuse also has a mandate for co-ordination, but its focus is outside government. (It is not a subject for this report because it was examined in a comprehensive evaluation in 1993.) The Memorandum to Cabinet for the renewal of the Drug Strategy specified that the mandate of the Canada's Drug Strategy Secretariat comprised co-ordination, data collection, communication of the Strategy, and evaluation.

The Secretariat has a small staff of five, an Executive Director, a Senior Advisor on demand reduction, a Senior Advisor on law enforcement, a Communications Executive, and one support staff position. Since its beginnings, there has been considerable turnover in the position of Communications Executive, and the enforcement advisor position has been filled only since January, 1993. The Secretariat's organizational home has changed many times in its brief history. Originally it reported to the Deputy Minister of Health Canada, then to the Associate Deputy Minister of Health Canada (1992), then to the Assistant Deputy Minister of the Policy and Consultation Branch (1993), then to the Health Programs and

Promotion Branch reporting directly to the Assistant Deputy Minister (1994), and now, with this Branch's recent re-organization, it reports to the Director General of a new, as yet un-named, Directorate and, for the first time, the Executive Director has been given line authority over Drug Strategy programming, namely, the Alcohol and Other Drugs Programs Unit of Health Canada. Throughout these organizational changes, its core mandate has remained stable, but it has also had different additional responsibilities for such things as Ministerial correspondence, policy advice, other Branch-specific responsibilities, and representing Health Canada and Canada's Drug Strategy at meetings of international organizations such as the United Nations International Drug Control Program and the Inter-American Drug Abuse Control Commission (CICAD). While many of these roles are important for the Secretariat to most fully respond to its mandate, that the Secretariat has acquired additional responsibilities has meant that less time is available for its primary mandate, and during some periods, very much less time.

Location

Given that the Secretariat was a creation of the lead department for Canada's Drug Strategy, it is at least natural from a historical point of view that the central co-ordinating body be housed in Health Canada. One of the constant challenges for the Secretariat, however, has been to have itself regarded as representing Canada's Drug Strategy, not just Health Canada. It would appear, judging from the mid-term reports from the other departments, that the Canada's Drug Strategy Secretariat is often regarded as representing primarily the interests of Health Canada. Despite this general perception from without, however, it would be a mistake conclude that the Secretariat has restricted itself to representing the interests of Health Canada alone. Paradoxically, within Health Canada, often it is seen as representing interests outside that department. For example, one commonly hears it said there that the Canada's Drug Strategy Secretariat represents the law enforcement aspect of the Strategy more than demand reduction, a staple of Health Canada. The Canada's Drug Strategy Secretariat is often seen by those within Health Canada as being responsible, not for any activities within that department, but for cross-department co-ordination alone.

The Secretariat believes that its position as Strategy co-ordinator has been weakened by its being placed within one of the line Branches of Health Canada, a Branch that has a heavy responsibility for programs within the prevention domain of Canada's Drug Strategy. This makes it more difficult for the Canada's Drug Strategy Secretariat to

convince other players within Health Canada and elsewhere in the federal government that it acts on behalf of the entire Strategy. It is difficult to convince other departments to regard it as representing them and not just Health Canada, and ironically it remains difficult to convince Health Canada officials that it represents them, too.

The realities facing the Secretariat also include the degree to which it is accepted as co-ordinator of the entire Strategy, at least in the sense of having a moral authority to do so. Most departmental mid-term review reports, while recognizing that the Memorandum to Cabinet gave the Secretariat a mandate to co-ordinate, spent very little time discussing its role. These reports frequently mentioned the lack of clarity regarding what was to be accomplished by way of co-ordination, often stated that the Secretariat is identified more with Health Canada than with Canada's Drug Strategy as a whole, suggested that it is more a source of information than a co-ordinator, but often pointed to its potential to co-ordinate. Interestingly, where a report discussed this potential, it tended to refer to co-ordination of programs, not only of high level policies. Indeed, the Secretariat is seen as being in a good position to identify opportunities for programs to better complement one another and work jointly towards shared goals.

Unclear Role

The specific ways in which the Secretariat was to co-ordinate were not described in the Memorandum to Cabinet, but were left to it to determine. It was to work with the federal partners to specify, beyond the general description offered in the Memorandum to Cabinet, the objectives of the Strategy itself. Beyond these tasks, the Canada's Drug Strategy Secretariat was to develop data, improve communications and the visibility of Canada's Drug Strategy, and to co-ordinate the evaluation work of the participating departments. This latter task was largely delegated to the Program Evaluation Division of Health Canada to ensure that the evaluation has a necessary degree of independence from the Strategy itself. One can note that each of these additional tasks involves co-ordinating work with other organizations.

The Canada's Drug Strategy Secretariat has yet to forge a clear niche for itself within Canada's Drug Strategy. One confusion, notable for its persistence, is over the respective roles of the Secretariat and the Canadian Centre on Substance Abuse. For years confusion has existed over the roles of these two organizations; despite attempts by both organizations to clarify their mandates and the differences between them, confusion remains. This general problem can only weaken the

ability of the Secretariat to act as a co-ordinator and can only weaken the benefits that were supposed to accrue to Canadians from co-ordinating the drug-related activities of the seven participating departments.

Early in 1993, the Evaluation Working Group presented a discussion paper to the Canada's Drug Strategy Secretariat on the early state of the Drug Strategy with regard to targeting, co-ordination, and the information base. (See Appendix B.) In this paper, the Group reported that co-ordination was weak, owing at least in part to the absence of clear co-ordination goals. The Evaluation Working Group recommended to the Secretariat that it take upon itself to develop, in conjunction with the participating departments, clear goals for co-ordination. It was obvious to no one what sort of co-ordination was expected of Canada's Drug Strategy, what co-ordination was to accomplish, who it was to involve, or precisely who was responsible for its taking place. All of this was left to the Canada's Drug Strategy Secretariat to define. In response to this paper, the Secretariat conducted a series of bilateral meetings with each of the participating departments. In general, those interviewed were the members of a committee called the Interdepartmental Committee for Canada's Drug Strategy.

The results of the bilateral meetings revealed the divergent thoughts of this group, and therefore, the divergence of thinking within the Drug Strategy. Among other things, the Canada's Drug Strategy Secretariat asked the members of the committee about the role that the Secretariat ought to play in the Strategy. The range of responses was remarkable. Some wanted the Canada's Drug Strategy Secretariat to play virtually no role at all while others wanted to see it play a very strong role and have a considerable amount of authority to direct the Drug Strategy and its resources. Unfortunately, these dissimilar responses were poor guides for the Secretariat with regard to determining its role in the Strategy or clarifying the expectations for co-ordination. The Secretariat judged that the potential for consensus was minimal, and its officials took no further action. This situation remains. At the time that this report was written, the Secretariat had yet to develop co-ordination goals or to define a clear role for itself, a full five years after its creation. This has unquestionably hampered the effectiveness with which it has discharged its responsibilities for co-ordination.

Authorities

One reason often offered in explanation is the lack of functional or line authority that the Canada's Drug Strategy Secretariat has to co-

ordinate across departments or even within its home department, Health Canada. However, it is not fully evident that lack of functional authority is the problem here. There are ways to have co-ordination take place without having the authority to order its occurrence. And even if the Canada's Drug Strategy Secretariat had functional authority over the federal Strategy partners, it is far from clear that it would, by this alone, succeed in its co-ordination responsibilities. Departments, after all, enjoy a considerable degree of autonomy over their own programming.

Functional authority is neither a necessary nor a sufficient condition for successful co-ordination. What is essential is that Drug Strategy "partners" accept the basic premises that are to bring them together under a single initiative, that all partners accept a set of common goals, have the same understanding of what these goals are and how they are to be accomplished. Again, this is lacking in Canada's Drug Strategy, and, as a result, it remains largely a set of distinct program efforts linked through a single Memorandum to Cabinet.

Moral Authority

The Canada's Drug Strategy Secretariat could play an important role in bringing this sort of understanding and acceptance about through what one might call "moral authority". This is the influence that an organization is able to exercise by virtue of its expertise and the trust and confidence that other organizations and their officials have in it. Neither line nor functional authorities are, strictly speaking, necessary for having considerable moral authority. Taking appropriate action, however, is essential. The Canada's Drug Strategy Secretariat has established working groups and committees through which they could exercise a moral authority to improve co-ordination of Canada's Drug Strategy. The two most important groups in this respect for the Strategy as a whole are the Canada's Drug Strategy Inter-departmental Committee and the Steering Committee. However, there are other venues that the Secretariat can and has used, such as the Canadian Association of Chiefs of Police and the Health Enforcement Partnership Committee. The recent work of the Secretariat with these two organizations demonstrates that there is real potential for them to influence organizations and further the interests of Canada's Drug Strategy.

Two examples: Canadian Association of Chiefs of Police

Roughly two years ago, the Secretariat made a presentation about the Drug Strategy to the Drug Abuse Committee of the Canadian Association of Chiefs of Police. Following this presentation, the Secretariat official was invited to become a member of the Committee

and is now the only representative of the federal government (outside of federal police forces) on this organization. The Secretariat provides information about the Drug Strategy and the issues it faces to this police organization, provides some financial support to their educational projects (videos and research, for example), and provides a connection between the Committee on Drug Abuse and other bodies of the federal government. For example, the AIDS Secretariat of Health Canada was brought into contact with this Committee through the Drug Strategy Secretariat's effort. This led to an improved understanding of enforcement-related AIDS issues, such as needle exchange services, and consequently an enforcement of drug laws that was more in keeping with the harm reduction objectives of Canada's Drug Strategy. Those involved in the work of the Secretariat with the Canadian Association of Chiefs of Police state that they are very appreciative of the co-ordination that it has made possible.

Health and Enforcement

The Secretariat has embarked, with the Canadian Centre on Substance Abuse, on a joint project, "Health and Enforcement in Partnership", to explore the possible forms that collaboration between law enforcement and health organizations might take. The general method they are using is to learn about existing forms of collaboration with the intention of developing recommendations on this basis for additional collaboration. The overall objective of the project is to facilitate co-operation between the two approaches to drug problems, something that most feel is rare. The Secretariat established a non-funded committee to oversee this project and has managed to develop a pool of resources for small ventures. The Canadian Association of Chiefs of Police have a seat on the Health and Enforcement Partnership Committee. Although in its infancy, this proactive effort at co-ordination is thought to have potential to bridge the historical gap between health and enforcement sectors in the substance abuse field.

Need to be more proactive

Until these recent examples, the Canada's Drug Strategy Secretariat had shown a reluctance to proactively encourage co-ordination, whether it be with respect to policy, programming, or information management. A good example of this was its reaction to the failure to achieve co-ordination goals of the bilateral meetings with members of the Canada's Drug Strategy Inter-departmental Committee. Rather than persist in the challenge of establishing these goals and clarifying its role, the Secretariat chose to discontinue the project. In general, instead of taking a strong pro-active role in pursuing the benefits of co-ordination, the Secretariat has chosen to focus more on acting as a

convenor of meetings to share information about individual program activities, on being the "conscience" of the Strategy, and on representing Canada's Drug Strategy on the international stage. The members of the Inter-departmental Committee appear to have acquiesced in this situation.

Performing these activities is unquestionably of value. The meetings of committees such as the Inter-departmental Committee do bring together people and organizations that would normally not interact, that would not normally share information. The level of mutual understanding has been somewhat improved amongst the participants. The Secretariat does attempt, in these meetings and in other fora, to keep the overall purpose and concept of Canada's Drug Strategy before the participants, and does bring the Canadian approach to drug issues to the international stage. These are all good starting points for a fuller co-ordination of Canada's Drug Strategy. But they must be seen as starting points, not as the final aim of co-ordination.

Information-sharing is co-ordination only in a weak sense; it is vital to a fuller co-ordination, but not in itself sufficient. So long as inter-departmental co-ordination remains mostly in the form of information-sharing, the Drug Strategy will remain essentially a set of autonomous programs. The potential for stronger co-ordination, especially regarding policy development and program design, is wide. Through actions such as those mentioned earlier, the Canada's Drug Strategy Secretariat can gradually establish the sort of moral authority that will help it to fulfil its mandate to co-ordinate the Drug Strategy. But the Strategy requires a more proactive intervention on the part of the Secretariat and more active involvement by the Inter-departmental Committee and Steering Committee memberships for this potential to be realized.

ACCOUNTABILITY

The accountability structures within Canada's Drug Strategy for inter-departmental co-ordination are not clearly defined. At the inception of Phase II, there was literally no organization "in-charge" of Canada's Drug Strategy as a whole. And there was, until late 1994, no committee or other organization within the Strategy with the mandate and the authority to co-ordinate between departments. Thus, for the greater part of Phase II, it has fallen to the Canada's Drug Strategy Secretariat to attempt to co-ordinate between departments, an unenviable task that it was not well equipped to carry out, especially in an environment lacking a tradition for strong co-ordination.

The Canada's Drug Strategy Secretariat is hampered in fulfilling its mandate for co-ordination, not only by having no line authority, but by the absence of any clear accountability structure for Canada's Drug Strategy as a unity. Aside from the inter-departmental evaluation, there are no accountability provisions for the entire Strategy. Of course, all normal departmental accountability requirements apply to the Strategy, but there is no "inter-departmental accountability" for performance, for meeting Strategy objectives. The Canada's Drug Strategy Secretariat has no role here, except for presenting itself as the "conscience" of the Strategy and encouraging partners to take an inter-departmental, co-ordinated approach to Strategy programming. Again, there is no organization "in charge" of Canada's Drug Strategy as a single program entity. There are rather organizations in charge of only the component parts.

As a result, there is really no sense in which Canada's Drug Strategy is, as a single initiative, responsible for achieving the harm reduction objectives broadly stated in the Memorandum to Cabinet. Each department has its own responsibilities, but there is not a strong sense of shared responsibility and shared accountability for meeting Strategy-wide objectives. Given this, it is not surprising that departmental concerns over-ride strategy concerns. This is a significant problem in the design of inter-departmental initiatives.

Two Committees

There exist two committees that have full representation of the federal partners in Canada's Drug Strategy and that have the potential to be accountable co-ordination mechanisms that the Secretariat could exploit to fulfil its mandate and the expectations of Canada's Drug Strategy. One, the Inter-departmental Committee of Canada's Drug Strategy, was established in 1993 by the Secretariat. Its members are program managers from each participating department. It was originally intended to play a co-ordinating role at the program level and, although it has the potential to do so, it has not been successful to date. Meetings are infrequent, the last having occurred in November, 1994, and consist mostly in information sharing, the bulk of this information being supplied by Secretariat officials. Participation by the other members tends to be minor. Because the agendas of these meetings have been limited to sharing information, the potential of this Committee to co-ordinate program activities, program design, or policy setting remains to be determined and remains to be used. Some committee members have expressed disappointment that the committee is less productive than it might be in co-ordinating the work of federal Drug Strategy partners.

The other organization with potential to co-ordinate between departments is the Interdepartmental Steering Committee, which is composed of the Assistant Deputy Ministers responsible for programs in the seven departments involved in the Strategy and with representation from the Treasury Board's Programs Branch. This committee was formed in 1992, but its mandate was steering only the evaluation. However, because of the lack of any committee of senior managers to steer the Drug Strategy itself, the Program Evaluation Division of Health Canada worked with the Canada's Drug Strategy Secretariat to have the committee's mandate expanded to include steering the Strategy itself, not just its evaluation. The new mandate was adopted by the Committee only in late 1994, and includes provisions for it to:

- convene meetings to discuss issues of importance to the overall Strategy, especially concerning its co-ordination and the setting of its priorities.
- work with the Canada's Drug Strategy Secretariat to develop co-ordination goals and to identify the means for bringing them about.
- actively encourage and support the strengthening of the co-ordination of Canada's Drug Strategy in order to improve its overall effectiveness and its cost-effectiveness.
- work with the Canada Drug Strategy Secretariat to try to resolve any disputes or issues of contention amongst Strategy partners.
- work with the Canada's Drug Strategy Secretariat in developing the Memorandum to Cabinet for the renewal of Canada's Drug Strategy in 1997.

This could represent an important step towards stronger co-ordination, though it remains to be seen how effective the Committee will be at improving co-ordination within Canada's Drug Strategy.

OTHER SECRETARIAT CO-ORDINATING ACTIVITIES

Most of the Secretariat's co-ordination work has been of an inter-departmental nature, however, they have done some work of particular interest to Health Canada, their home department. Of special interest to Health Canada, it organized a workshop on out-of-the-mainstream youth that included participants from the Health Promotion and

Programs Branch and organizations outside the federal government, and it has participated in numerous workshops and conferences arranged by others. The review notes that the level of the Secretariat's co-ordination activity has increased over the past few months from previous levels. For example, the Secretariat drafted in conjunction with Drug Strategy officials from each Branch and officials representing related initiatives such as the National AIDS Strategy and the Family Violence initiative, a departmental position on the vague and controversial concept of 'harm reduction', as mentioned above.

New Legislation

Bill C-7, the Controlled Substances Act, has provided another recent opportunity for the Canada's Drug Strategy Secretariat to co-ordinate within Health Canada. This draft bill, which has had a very long history predating Canada's Drug Strategy, Phase I, remains difficult and has been subjected to numerous changes. In order to provide the Parliamentary Committee with a Health Canada perspective on some the areas under recent discussion, the Secretariat has over the last six months brought together Drug Strategy representatives from each Branch at Health Canada as well as representatives from related Strategies, most notably from the AIDS Strategy, to develop a departmental consensus regarding aspects of the draft legislation itself and its policy implications. It is important to note that the Secretariat also worked on behalf of other federal departments in keeping them apprised of the issues implied in the debate regarding the Bill.

Communications: another co-ordination role

The Memorandum to Cabinet described Canada's Drug Strategy, Phase I as the best kept secret in town and assigned to the Secretariat the task of increasing the Strategy's visibility. This task they interpret in a threefold way, namely, visibility in the eyes of the public, amongst the federal government partners, and amongst the Ministers of the federal partner Departments. The Communications Executive has assigned priority to communications within government and plans to focus on external communications once internal communications are improved. This is, in part, to ensure that messages to the public are consistent across all departments.

The Secretariat believes that it is important that each federal partner have a good understanding of what each is contributing to Canada's Drug Strategy and that all Ministers share in this understanding. To this end, the Secretariat formed the Inter-departmental Communications Working Group to:

- exchange information and develop communications activities in support of the Strategy,
- co-ordinate Ministerial and Departmental participation in Drug Awareness Week,
- provide a forum for identifying areas of mutual concern, and
- monitor and evaluate communications activities relating to Canada's Drug Strategy.

Among the communications products released by the Secretariat are a document, **Canada's Drug Strategy, Phase II, A Situation Paper**, which describes the activities of each participating department, and a logo for Canada's Drug Strategy that appears on all Drug Strategy publications regardless of department of origin. The Secretariat has involved communications more in program planning, trying to ensure, for example, that communities that receive Drug Strategy-funded services are aware of the source of the funds. In the future, the Secretariat plans to direct more communications about Canada's Drug Strategy as a whole directly to the public.

No Program Role

The sort of co-ordination work carried out by the Canada's Drug Strategy Secretariat is certainly to be valued. One notes that it is primarily of a conceptual nature, concerning policy and legislation and not programming. The Secretariat has been less than proactive in fostering the co-ordination of programming between departments. Why it has not been more active in this regard may be explained in part by the widely-held view that the Secretariat must not play any sort of program role. This seems to have been taken to mean that the Secretariat can do little more than invite officials to meetings of the Inter Departmental Committee. There is some resistance, then, to the Secretariat taking on a strong role in co-ordinating programs.

This reasoning is curious, however. If the Canada's Drug Strategy Secretariat is to co-ordinate between departments, that would suggest co-ordinating the programs delivered by these departments. By and large, Canada's Drug Strategy is a set of programs and to co-ordinate it would seem to be to co-ordinate its programs. One could argue, however, that the Secretariat is in a good position to identify potential areas where programs could co-ordinate their activities, be they direct program delivery, information management, or program design. The Secretariat has or potentially has a strong awareness of what all players in the Strategy are doing, an awareness not to be expected of any of the players themselves. With this broad and comprehensive perspective, they ought to be in a better position to facilitate co-

ordination at not only the level of policy, but of program design and delivery as well.

CDSS POTENTIAL

There is nothing to indicate that the original reasons for establishing the Canada's Drug Strategy Secretariat are no longer valid. Indeed, the experiences of federal multi-departmental initiatives reinforce the idea of establishing special organizations with responsibility for cross-departmental co-ordination, communications, and data development or information management. The federal government has comparatively little experience in managing and delivering multi-departmental initiatives, and it should come as no surprise that cross-departmental secretariats like the Canada's Drug Strategy Secretariat have experienced some difficulty in fulfilling their mandates. These are new organizations with responsibilities that are unfamiliar to them and to the departments that they are to serve. However, despite the undeniable difficulty of the assignment, it remains disappointing that Canada's Drug Strategy, its Inter-departmental Committee, Health Canada, and the Canada's Drug Strategy Secretariat as the organization with the responsibility to co-ordinate, have yet to establish a clear idea of what a co-ordinated Drug Strategy is or should be.

The potential of the Canada's Drug Strategy Secretariat to add value to the Strategy, to increase its cost-effectiveness, is real and has begun to show itself during the past few months. Its potential is not yet fully realized for reasons mentioned above and that will be described in the following chapters of this report. However, without an organization like the Canada's Drug Strategy Secretariat, it is highly unlikely that the benefits intended by placing the federal government's substance abuse programs under a single initiative would arise of their own accord. To achieve effective inter-departmental co-ordination, an organization is required with the express responsibility to carry it out. But it is important to note that having an organization is not in itself sufficient. There must be a willingness on the part of the participating departments to have their programs co-ordinated with those of other departments and to have the Secretariat play a role in facilitating this co-ordination. Thus, the responsibility for co-ordination ultimately rests with all Drug Strategy partners.

chapter 3
targeting

Is the division of funding between prevention, enforcement, and treatment appropriate?

Canada's Drug Strategy is intended to be a comprehensive and balanced initiative, and these two qualities are to lead to greater effectiveness. To a large degree, the balance is to be between what is loosely described as demand reduction activities and as supply reduction activities, the assumption being that before the Drug Strategy, there was insufficient federal demand reduction in the drug field. The National Drug Strategy (1987-1992) had a rough division of funding of 70% for demand reduction and 30% for supply controls. According to the Memorandum to Cabinet, this proportion changed under Phase II of Canada's Drug Strategy which saw $40% of the funds directed towards supply controls and 60% towards demand reduction. The main reason for this change in funding was the introduction of the Integrated Anti-Drug Profiteering Pilot Units in Phase II.

CDS: comprehensive and balanced?

The Strategy is to be comprehensive in the sense that it includes the three generally prevailing areas of activity in the alcohol and drug field, prevention and treatment (demand reduction) and law enforcement (supply reduction). Despite popular usage, there are not sharp conceptual distinctions between these types of activity. Enforcing the law is to not only reduce the supply of black market psychoactive substances through seizures but, by being a deterrent, is to reduce the demand for them as well. Prevention often takes the form of familiarizing people of drug and alcohol legislation in the hope that it will deter consumption and participation in the illegal supply chain. Treatment is often referred to as tertiary prevention and sometimes is used in sentencing offenders of alcohol and drug laws. The boundaries between these three domains are blurred, but they will be followed here because they are familiar. That these boundaries are blurred, however, suggests that federal drug programs should be good candidates for a co-ordinated cross-departmental initiative.

The central questions are simply, what is the most effective and cost-effective way to reach the country's objective of reducing the harm to individuals, families and communities resulting from the consumption of alcohol and other psychoactive drugs? What is the most effective design for this multi-departmental, multi-sectoral program? Even though there are no sharp conceptual boundaries between the demand and supply reduction fields, and despite there being a single goal to bind the elements of Canada's Drug Strategy together, it remains a fact that the institutions involved in delivering alcohol and drug-related programs often work as if there are strong boundaries between them. Consequently, Canada's Drug Strategy, rather than being designed around a single national alcohol and drug policy that is accepted by all program delivery organizations, is instead the result of an evolving historical tradition of programming in Canada, a tradition that has seen demand reduction and supply reduction programs develop at different times and in different organizations.

An evolving tradition

Drug and alcohol programming in Canada began as law enforcement, evolved to include treatment, and more recently has come to encompass a variety of preventive activities such as education, social marketing, community development, and product regulation. Often, these activities were conducted by new organizations created for these specific purposes. They did not often involve change in existing organizations whereby one type of activity was reduced and another begun on the grounds that a more comprehensive and balanced effort would be more effective. Rather, the evolution of the drug field has mostly been one of augmentation, with more and more types of program being delivered by more and more organizations as our theories changed and knowledge in the drug field increased. Although a common cause can be described to cover what these organizations do, it would be an overstatement to say that they act as a common front. One of the most recent developments in the evolution of drug programming is the attack on the proceeds of drug crime. This is an indirect form of supply control designed to deter drug crime by removing its economic rewards.

There is no exact science of drug programming that can provide fully certain guidelines for decisions on what type of programs to fund or on what is the most effective combination of programs. Consequently, the question of whether the Canada's Drug Strategy funding scheme is appropriate cannot be answered definitively. What would count as the optimum balance among prevention, treatment, law enforcement, and any other type of programming that might appear in the future, is

essentially unknown now. Today, the received view maintains that none can succeed in isolation; but it is unknown just how much more effective these program areas will be in combination, whether that combination be co-ordinated or not.

In 1995 we find yet another degree of interest in lessening the criminal sanctions against what are deemed minor drug offenses. The reasoning is often similar to that expressed in the early 1970s, during the time of the LeDain Commission, though today it is often couched in the language of harm reduction. The arguments are difficult to adjudicate because of a paucity of information about the consequences of taking a strikingly different approach to solving alcohol and drug related problems. It is clear that problems remain and that persons inside and outside government want to solve them. It is not clear that anyone has solutions that will be marked improvements over the status quo, despite its shortcomings which are undeniably displayed by the continuance of substance abuse problems in Canadian society.

More information needed?

It is tempting to respond by saying that if more research were done we might then be in a position to make completely rational choices about how to allocate funds for alcohol and drug programs. This would require a massive undertaking into the relative effectiveness of direct drug and alcohol programming and into the broader area of what factors cause our alcohol and drug problems in the first place. Research into the determinants of health and of health behaviours is in the infancy stages now. It is difficult to imagine that we will soon come to have enough information to establish completely certain decisions about what sorts of alcohol and drug programs to offer. It is hoped, however, that the final evaluation can make a contribution to this issue.

There are 37 federal program areas funded under Canada's Drug Strategy, Phase II. Of these, 21 can be classed as being in the prevention area, 18 as being in the enforcement and control area, and 7 as being involved in treatment. (Some programs function in more than one area.)

Alcohol, prescription drugs, street drugs: another targeting issue

Canada's Drug Strategy covers alcohol and those psychoactive drugs subject to the Narcotic Control Act and the Food and Drug Act, Parts III and IV, and certain other substances such as anabolic steroids and solvents. It does not include tobacco, over-the-counter drugs, or non-psychoactive drugs. The question presents itself, is the attention and

funding given to these different substances by Canada's Drug Strategy appropriate?

One approach to take is to consider the relative severity of the problem associated with each substance and to allocate program resources accordingly, all other things being equal. In 1987, the House of Commons Standing Committee on National Health and Welfare reported that alcohol is the most widely abused drug in Canada and is also "the most damaging in terms of prevalence of drug-related illness, premature death, accidents, family disruption, violence and other social and personal problems". (Booze, Pills and Dope, p. 1) In 1991, the Canada's Drug Strategy Secretariat conducted a series of Canada-wide consultations in preparation for the renewal of the Strategy. Those consulted "pointed to alcohol abuse as the major problem in their jurisdiction. They expressed concern that more initiatives need to be directed towards solving the alcohol abuse problem." (Canada's Drug Strategy Consultations, 1991, p. 2) And the publicity from the Drug Strategy Secretariat affirms that alcohol presents the number one drug problem in Canada. The abuse of prescription drugs is described by Canada's Drug Strategy as the second-highest priority with street drugs third on the list ahead of the emerging problem of steroid abuse. Despite these stated priorities, Canada's Drug Strategy appears to place the highest emphasis upon street drugs, to a large extent because interdiction efforts are mostly focused there.

The proportion of programs dealing with street drugs would appear to conflict with the priority assigned to them by Canada's Drug Strategy. There are 37 program areas funded by Canada's Drug Strategy (following the breakdown in the Memorandum to Cabinet). Of these, 35 are concerned with street drugs, 18 with alcohol and 13 have some content regarding prescription drugs. (Some programs deal with more than one drug type.)

TARGET POPULATIONS

The Memorandum to Cabinet did not dictate to Canada's Drug Strategy specific target populations; it did, however, make it clear that programs were to be more targeted to high-risk groups such as street kids, dropouts, off-reserve aboriginals, the unemployed, seniors, women, impaired drivers, and dysfunctional families than in Phase I. Some Drug Strategy programs are not easily amenable to restriction in this way. For example, Health Canada laboratories analyze drug samples for police forces to assist in prosecutions and in certain types of investigations. Their responsibility is to analyze those samples sent

to them by the police. They cannot restrict their activities to only certain types of samples or to those sent by only specially targeted police forces. Health Canada's laboratories are the only sources of this service in Canada. Consequently, the issue of targeting does not arise for this specific activity; and there are other examples where the new directive for restricted targeting does not apply.

Nevertheless, this shift towards high-risk sub-populations marks a significant change. During Phase I, the Drug Strategy gave attention to the general population; this was motivated in part by the view that it is best to direct government efforts towards preventing non-consumers from becoming consumers and non-abusers from becoming abusers and to raise public awareness about the issues. Phase II moves away from primary prevention in favour of a concerted effort to grapple with the problems of the high-risk population, including those who already have serious problems with psychoactive drugs. To a significant extent, this decision was made on the basis of consultations with the provinces carried out in 1991 by the Canada's Drug Strategy Secretariat. However, this change did not come without controversy; there remain some provinces and some special interest groups who continue to maintain that it is more effective to target the general population and, some argue, to do so with the intention of promoting abstinence rather than keeping harm levels to a minimum. This report can neither vindicate nor refute the decision to change program targets, but it is hoped that the final evaluation will be able to begin doing so as data become available on trends in consumption and harm levels and on other indicators of effectiveness.

OTHER STRATEGIES

Canada's Drug Strategy is not alone in delivering programs to people whose health and well-being are at risk. Other federal inter-departmental strategies, such as the Family Violence Initiative and the National AIDS Strategy target high-risk populations. It is often the case that their targeted populations overlap, that it is the very same people who are the targets for different strategies and programs. As programming is now organized in most of these multi-departmental initiatives, it is problems that are the primary targets with attention to sub-populations being secondary. That is, once one has targeted a problem, one then can proceed to target specific sub-populations that suffer from that problem. However, Health Canada has adopted a determinants of health approach that might suggest a targeting primarily of populations, because it is known that certain sub-populations suffer from a wide variety of health problems. There is a significant policy question that can be raised here, but which this

study has no mandate to answer. The question is whether interdepartmental strategies should be defined according to problem or according to those sub-populations that suffer, perhaps from multiple problems. More discussion of this issue is contained later in this report.

chapter 4
the information base

BACKGROUND

The Evaluation Framework of 1992 treated information as one of the four mechanisms for enhancing Canada's Drug Strategy programs. This gives it an importance appropriate for a time of fiscal restraint. Government is no longer able to enhance programming primarily by enlarging budgets. Rather, programming will be improved by such measures as improved targeting, co-ordination, and improved development and use of information. Appeal to sound information is essential to policy development, program design, program targeting, and co-ordination. Sound information has always been essential to making rational decisions, but, now, its importance also lies in providing services in the most cost-effective manner possible. This interest fits well with the government's current emphasis upon evidence-based decision-making, particularly with regard to macro-level policies, priority-setting, and resource allocation.

CDS Secretariat

The Memorandum to Cabinet noted the requirement for information that would help Canada's Drug Strategy determine its degree of success and accordingly mandated the Secretariat to collect data that would be useful for policy development, program design, and evaluation. In consultation with the Canadian Centre on Substance Abuse and other Strategy partners, the Secretariat has chosen to fund the following projects, each of which should provide information fundamental to the objectives of Canada's Drug Strategy:

1. A project to develop an alcohol and drug epidemiological data base. The Canadian Centre on Substance Abuse is carrying out the project which is designed to improve drug-related epidemiological data and thereby improve policy and program planning at both a national and local level. Also involved are the Secretariat, the Alcohol and Other Drugs Programs Unit, the National Health Research and Development Program, the

RCMP, some provincial representatives, and some academics. Resulting data should be of use to future evaluation work in this field.

2. A project to develop a model for collecting data that indicate the economic costs of drug-related harms. This project, too, is being carried out by the Canadian Centre on Substance Abuse, and is international in scope. The project is expected to include a series of workshops beginning in the autumn of 1995. Economic harm was among those drug-related harms identified by the evaluation framework as falling under the general harm reduction objective of Canada's Drug Strategy.

3. A project to co-ordinate drug-related research results in Canada and the United States. The Canada's Drug Strategy Secretariat is managing a contract. The aim of this project is to maximize the benefit to Canada of drug-related research done in other countries, most notably the United States.

4. A project to develop a system for collecting drug-related hospital emergency room data; the current Statistics Canada data on morbidity do not include those treated in emergency rooms but not subsequently admitted to hospital.

The Canada's Drug Strategy Secretariat engaged in a brief consultation process with Canada's Drug Strategy partners to determine the Strategy's data needs. These projects are the result.

Departmental reports

Each departmental report includes a section on information. Many refer to information-related projects that were made possible by Canada's Drug Strategy funding, although some departments indicated that the Strategy had not made a difference to what information they produce or to the ways that it is managed or used. Frequent mention was made of two Canada's Drug Strategy Secretariat products, the "Blue Book" (a regularly updated collection of one or two page accounts of what each Strategy-funded program is doing) and "Canada's Drug Strategy, Phase II: A Situation Paper" (a more synthesized department by department synopsis of Drug Strategy activities). Some departments mentioned the meetings of the Inter-Departmental Committee held to exchange information between departments.

Notable by their absence in these reports are mentions of information-related activity for the entire Strategy, of information projects carried out jointly between departments or of intended benefit to more than the programs of a single department, of Strategy-wide information needs, a plan for information collection, data development and dissemination. Even the special information projects of the Secretariat listed above went unreported in all but one report (Health Canada's).

There has been no systematic and co-ordinated data needs assessment for Canada's Drug Strategy. Most data collection is program-specific, and it must be recognized that it is considerable. But what appear to be missing are the links between the information needs of Canada's Drug Strategy, the data and/or information that are actually produced, and, finally, the use of this information for decision-making. To put the point yet more generally, what appears to be missing is a plan that would integrate the production and use of information with the objectives of Canada's Drug Strategy. This problem is a manifestation of the general lack of inter-departmental co-ordination that Canada's Drug Strategy suffers from.

No plan for information management

Phase I of the Strategy did include a data needs assessment. A document was produced (The Psychoactive Substances Information System) but apparently little used. Although it formed the starting point of the consultations mentioned above, Phase II neither uses this old document nor has replaced it. Without a clear and well-publicized idea of what data are needed, for what, and by whom, the Drug Strategy risks making decisions on the basis of insufficient evidence, or of wasting money producing information that is not needed, that is not used because it is not properly disseminated or properly presented, or by duplicating effort.

There is some recognition of these problems. For example, the Health Promotion Directorate of Health Canada together with the Canadian Centre on Substance Abuse held workshops in 1993 on the usefulness of the National Alcohol and Drugs Survey. Among other things, they learned that the data resulting from the survey were often irrelevant to the needs of program delivery, were inaccessible or difficult to gain access to, were difficult to use except by academic researchers, and were inadequately analyzed for the needs of decision makers. In short, the survey produced good information for academic researchers but was less useful to government. Its successor, the Canada Alcohol and Drug Survey will attempt to improve its usefulness.

The experiences of Canada's Drug Strategy show a need for improvement in the management of knowledge and information. What is needed is:

- a co-ordinated understanding of what information is needed by Canada's Drug Strategy for developing policy and legislation, for designing and delivering programs;
- a co-ordinated plan for producing this information for the Drug Strategy as a whole, not just on a program by program basis;
- a way to ensure that the results of data collection and analysis are usable by those who make decisions; and
- a way to facilitate the profitable use of this information by those who make decisions.

There are a number of examples of decision-making processes that appear not to take full advantage of available information. One specific example is the development of the legislation to replace the Narcotic Control Act and the Food and Drugs Act, Parts III and IV. This legislation, which will affect all partners of Canada's Drug Strategy, has not in general been developed in concert with all federal Drug Strategy partners or with the Canada's Drug Strategy Secretariat and thereby may not have availed itself of all pertinent information. This is not in any way to pass judgement on the resulting legislation, which remains in draft form, but to comment on the process by which it has been developed over the years.

It is generally unclear how it is that Canada's Drug Strategy uses the enormous amount of data and information available in the substance abuse field. There was little evidence that the Drug Strategy was developed using the enforcement data bases maintained by the RCMP or Canada Customs, or the Health Protection Branch or that it took advantage of the survey information from the Health Promotion and Programs Branch or the information stored at the Canadian Centre on Substance Abuse's clearinghouse. Similarly, little evidence was presented exhibiting how this sort of information is used in designing programs or developing policy.

There exist, however, examples of beneficial information exchange, despite the lack of a Strategy-wide information plan. The shared work concerning off-reserve aboriginals brought about a sensible sharing of information between the RCMP, Solicitor General Canada, and Health Canada in designing programs for this population. The Integrated

Anti-Drug Profiteering Units have improved the sharing of information to improve enforcement practices. And there are fora for information exchange; the interdepartmental committees that meet to exchange information, and the Canadian Centre on Substance Abuse with its drug information clearinghouse, and the Canada's Drug Strategy Secretariat.

chapter 5
resources

A SUNSETTING INITIATIVE

Canada's Drug Strategy is a sunsetting initiative. However, given that such a large proportion of its funds is to supplement programs previously receiving A-base funds, were it to sunset would not automatically imply the cessation of the programs that fall under it. Some of the programs nominally included in Canada's Drug Strategy are fully funded through A-base budgets. Most, however, are at least partially funded through ongoing funds; very few receive their entire budgets through the Drug Strategy.

In these times of scarce resources, sunsetting initiatives have become a more popular way to fund programs. In theory, establishing sunsetting programs allows the government to respond to special problems without being committed to long-term expenditures. In the case of Canada's Drug Strategy, Phase I, the government was responding to a perceived unusual severity in alcohol and other drug-related problems in Canada. The Strategy was renewed for a second phase on the grounds that the problem persisted, that the balanced approach the Strategy represented was sound, and that it needed to be given a more focused set of targets for maximum effectiveness. Whether the degree of seriousness of Canada's drug problems will decline to the point that it is no longer necessary to inject these special funds cannot be rigorously predicted. However, if the need for sunsetting initiatives remains beyond Phase II, that is, beyond the ten years of this special initiative, the government must consider whether or not Canada's Drug Strategy ought to be a sunsetting initiative, whether it should be cancelled on the grounds that this sort of infusion of funds will not be effective in significantly ameliorating the problem, or whether the initiative should be given A-base funding. Strategy organizers must face the possibility, however, of non-renewal and plan for how it will deal with the loss of a substantial influx of funds. The loss of supplementary funds could bring about the collapse of the Strategy, especially the intended element of co-ordination. It is crucial to

recognize that the Strategy is not entirely dependent upon additional funds. Through the other means of program enhancement, it could continue to exist even with a loss of the sunsetting dollars.

BUDGET CUTS

The cuts to departmental budgets over the past few years have affected some Drug Strategy programs. Details are contained in the reports from individual departments. For an evaluation to be fair, it must take into account the actual funding received by a program. It would be patently unfair to assess a program on the assumption that it received a certain amount of money when it received, for example, only half its allocation.

The issue of budget cuts is complex for Canada's Drug Strategy. Given that many programs receive a combination of A-base and Drug Strategy dollars, it is difficult, perhaps arbitrary to describe the effects of cuts; even to describe a cutback as being to the A-base or to the Drug Strategy portion of the entire program budget becomes arbitrary. The fact of the matter, as far as the effectiveness of some of its programs is concerned, is that some programs had less money to work with than expected. The Strategy was, in some cases, to increase the effectiveness of a program by injecting more money into it. However, if the program's A-base funds are cut, this effectively could nullify any advantages resulting from an infusion of Drug Strategy funds. It is important to assessing program performance, then, to take into account any cuts to program funding, whether it be to the A-base or to a special infusion of funds from a sunsetting program.

"Double Jeopardy"

It is a matter of some controversy how departments manage funding cuts. One question that often arises is whether Strategies are exempt from budget cuts. From one point of view, it does not matter: a cut is a cut, be it from one budget or another. In the end, a program has fewer dollars to work with. However, there is often said to be a special consideration with sunsetting dollars that some departments have come to call "double jeopardy". A Health Canada report on National Strategies from March, 1994, describes it this way:

> Double jeopardy refers to the situation whereby Strategy funds are included in the base upon which this department must effect cuts and yet these funds are treated differently from departmental funds at renewal. Should a sunsetting program not be renewed, the department's reference levels would be reduced by the full value of the sunsetting program as originally approved, regardless of whether the program had

been subject to reduction. The implications of this TBS policy are:

- the inclusion of sunsetting programs in the A-base for the purpose of calculating departmental reductions coupled with a "full payback" policy creates a "double jeopardy situation for those departments which for whatever reasons, target sunsetting programs for reduction.
- to avoid the above situation, departments would be forced to seek the full extent of reductions from non-sunsetting programs, which results in an inordinate burden placed on ongoing programs far beyond the reduction levels intended by the proposed cuts.

In very general terms, the first of the jeopardies appears to be cuts to program budgets, as ordered by the Department of Finance and implemented by the Treasury Board; the second, the loss of the entire original allocation, as defined in the Treasury Board decision, when an initiative sunsets. Thus, at first glance, it would appear that, in a situation where a program has suffered budget cuts, including cuts to resources provided by a Strategy, the non-renewal of a sunsetting program would mean the loss of more than the original allocation, namely, the original allocation together with any resources implicated in a general budget cut. In a case where this occurred, a department would lose more money than was originally allocated to it through a Strategy. Clearly, were this to occur, being the recipient of a sunsetting Strategy would be a liability for a department, and one might predict that departments would come to have very little interest in taking part in sunsetting initiatives.

The question, however, is of the extent of the danger. Treasury Board officials confirmed in interviews that it is the Department of Finance's intention that sunsetting dollars be included in the base from which budget cuts are calculated. However, they also stressed that there has been relief given to departments for cuts to the grants and contributions portions of sunsetting programs. There has not yet been similar relief given for the operating and management dollars that have been cut, but the Board is aware that there is a problem and is trying to rectify it. This is, they stated, a very complex budget issue. Thus, it would appear that, while double jeopardy is a real problem, it may not be as serious a problem as some would have it because of the relief given on the grants and contributions budgets.

Shifting funds

It can happen that funds originally designated for a Strategy end up being used for other purposes. If Strategy dollars are not maintained as a completely separate budget item (as seems to be the case for Canada's Drug Strategy if the Main Estimates, Part III, are any guide), that is, if Strategy dollars are treated by a department in the same fashion as A-base dollars, then it could easily happen that they are used for other purposes. Canada's Drug Strategy is especially at risk of this happening because so much of its budget goes to supplement previously existing programs. As managers shift A-base dollars from one program area to another in the normal course of events, it can easily happen that Drug Strategy dollars get moved along with them. Aside from the original intentions of the Treasury Board for the use of this money not being met, the result of shifting money from the Drug Strategy to other program areas could be a reduction in the effectiveness of the Strategy. During prolonged periods of shrinking budgets, then, even Strategies whose funds are protected from budget cuts may be vulnerable to a form of "raiding", and thereby vulnerable to reduced effectiveness, both from the loss of Strategy dollars to other program areas and from the loss of A-base dollars from programs that the Strategy supports. The final evaluation study, set for completion in 1997, will attempt to assess whether Canada's Drug Strategy has suffered a loss in effectiveness as a result of budget reductions or transfers of funds to other program areas.

Possible responses

The framework for evaluating Canada's Drug Strategy referred to three orders of objectives for the Strategy, one of which was described as mechanisms for enhancing programs. This "third order", as it was called, included improved targeting, co-ordination, information, and resources. Budget supplements were cast as one of four ways to enhance programming. The point of this is that budget supplements are regarded as having no greater importance than the other mechanisms for improving program performance. In general, that one of these mechanisms is diminished should be compensated for, to the extent possible, by augmenting the others. Thus, the diminution of the budget supplements should, then, be compensated for by yet further improvements to targeting, co-ordination, and information.

The previous chapters, especially that on co-ordination, suggest that there may, indeed, be room for attempting these sorts of compensation. An obvious starting point is co-ordination with regard to funding itself. For example, some Drug Strategy programs lapsed funds during the first two years of Phase II. More creative co-ordination of resources could include a sharing of lapsed funds

identifiable as Strategy funds among the different partners, rather than have them simply lapse.

Cross-strategy connections

A somewhat more adventurous form of resource co-ordination would involve co-ordinating between related Strategies or major initiatives. Alcohol and other drug problems often occur along with other problems that the federal government is involved in rectifying, among them family violence, AIDS, mental health problems, problems with the well-being of children, and others. The connections between these problems and the programs that attempt to deal with them are ripe for exploitation to the benefit of all related programs. Further, a determinants of health approach to each of these problem areas will uncover similarities in the determinants that could be dealt with by a single program. More is said of this in the next chapter. At Health Canada, there has been some joint funding of programs between Canada's Drug Strategy, the National AIDS Strategy, and the Family Violence Initiative; further, it is planning to introduce an population health program that may integrate resources from different areas.

chapter 6
the environment of canada's drug strategy

The 1992 evaluation framework for Canada's Drug Strategy left open the possibility of reporting on issues beyond the bounds of the framework itself, which for this mid-term review were restricted to the four mechanisms for enhancing programs. A number of significant changes have taken place in the Drug Strategy's "environment" that ought to receive attention from Strategy officials. Some of these concern the policy environment within which the Strategy finds itself, some concern changes in the provinces, and others concern changes to the levels of drug-related harm experienced by Canadians. The reason for providing this information here is not to make judgements about the effectiveness of Canada's Drug Strategy at meeting its harm reduction objectives, but to provide an indication, before the final evaluation, of situations that demand the attention of Drug Strategy officials. The final evaluation will report on developments in each of these areas.

EXPANDING ROLE OF THE IADP UNITS

The success of the Integrated Anti-Drug Profiteering pilot units can be measured in more than the revenues they have generated from court ordered forfeitures of drug offender's assets. It is also reflected in a multi-jurisdictional approach to law enforcement that is being adopted in areas beyond drug crime. This partnering of police with federal Crown Counsel, Customs Officers, and forensic accountants has resulted in very efficient teams which have strategically attacked their designated targets, the upper echelons of organized crime.

Further, the success of IADP has clearly established the need for law enforcement to do more than just put offenders in prison. It recognizes that jailed offenders are still a threat to repeat their crimes unless they lose the means by which they can do business, their cash reserves. It has become clear that drug offenders, in particular dealers and distributors, maintain their power to do business only if they have the available cash flow to make purchases and pay distribution costs. Drug

dealing does not run on credit. Therefore, if they lose their profits, be they cash or assets, their threat to start up business again is diminished.

This has influenced the thinking of the RCMP when it comes to considering ways to combat other crimes where large profits are generated. For example, smuggling, fraud, and gambling are often just as lucrative as trafficking in illegal drugs. Players in these crimes get rich just as fast and are keen to launder their illegal wealth in the same manner as drug traffickers; and, like traffickers, theirs is a cash and carry business; therefore, no ready available source of cash means the person can't do business.

As a result, the RCMP and its IADP partners now recognize that proceeds of crime investigations, the raison d'être of IADP, must be the approach used in the area of smuggling and other forms of enterprise crime. This has resulted in the RCMP re-structuring their investigation units to create a new umbrella group referred to as the Economic Crime Directorate. This Directorate brings together the smuggling, enterprise crime, Anti-Drug Profiteering and Integrated Anti-Drug Profiteering units to take full advantage of the skills and expertise used in these investigations. What one now has is a similar approach being taken to those offenses that have a large proceeds of crime aspect. The result is an investigation process which addresses both the crime itself and the forfeiture of the ensuing proceeds of crime.

This new entity, the Integrated Proceeds of Crime Model, will serve as the basis for future development and expansion in the area of proceeds of crime investigations. Drug enforcement will continue to be an integral component of IPOC through the efforts of the ADP unit, and, until the end of Canada's Drug Strategy, Phase II, through the efforts of the IADP units. But the decision to expand the role of these units to all areas of enterprise crime accepts that the original linkage solely to drugs no longer applies. The investigation of proceeds of crime includes a broader group of crimes and recognizes that upper level drug offenders are quite often involved in the whole gamut of economic crime. This may have implications for the future of Canada's Drug Strategy that Strategy officials will need to take into account when they discuss the future of this multi-departmental initiative.

HEALTH CARE REFORM

Concern over the costs of the health care system and their contribution to federal and provincial deficits has prompted governments to begin to reform the system to reduce its costs. Activities at the federal level include the work of the National Forum on Health, and their contribution to the Federal, Provincial and Territorial Advisory Committee on Population Health, and the work within Health Canada on the issue, conducted by a large network of working groups. The provinces have tackled these issues individually and together through fora such as the Federal-Provincial-Territorial Advisory Committee. Many have begun to change their system of health care delivery, sometimes in ways that affect Canada's Drug Strategy.

Changes in the provinces

Over the past few years, many of the autonomous provincial addictions agencies have been dissolved and their functions assumed by ministries of health. Some representatives of the provincial addictions services regard these transfers as an indication of a declining importance of their work and clientele while others see them as a natural outcome of the view that alcohol and drug issues are health issues. No matter what the causes of this organizational change, which has affected all provinces and territories but Alberta, Manitoba, and Ontario,[2] it has meant for some discontinuity of the organization of addictions services and some changes in personnel. This has caused some difficulties in communications not only between the federal and provincial governments, but also between provinces. It is simply not always clear who one should contact in a given jurisdiction. This has obvious implications for co-ordination, it being virtually impossible without communications between partners. At the time of the interviews, many, including some Health Canada officials, expressed confusion over who represents certain provinces in the addictions field.

Not only has the transfer of responsibilities for addictions to health departments meant for some communications difficulties, the current reform of the health care system has added some of its own. One element of the reform movement is to devolve some responsibilities and authorities to regions or districts of some provinces in order for health programs to be more responsive to community needs. As authorities are transferred from ministry headquarters to the regions or districts, the power of the provincial headquarters may be reduced. Indeed, some of the provincial officials interviewed expressed the fear that regions might choose not to offer addictions programming at all. Some argued that it is becoming difficult to know who speaks for the province in the addictions field, the ministry or individual regions or

districts. Further, it can be unclear whether there is a single voice speaking for a province that has regionalized its addictions services, whether such a province has a single position on addictions issues. The implication for setting national policies is clear: if the federal government wishes to work with the provinces and territories as partners in setting national policies or in developing national programs, it may be more difficult establishing who are the partners than it was before the amalgamation of addictions services into health departments and before health care reform began. There is not only the matter of who has the authority to set policy, but the very simple problem of knowing who to contact, knowing who speaks for the province.

POLICY CHANGE AT HEALTH CANADA

Since the re-organization of government in 1993 which abolished Health and Welfare Canada, Health Canada has worked to establish a new mandate and a broad policy framework for carrying out its new mandate. The vision statement adopted by the Department reads:

> **Health Canada sees a renewed national health system that is based on a health determinants approach to population health and that ensures universal access to appropriate and cost-effective health care.**
>
> **This vision is sustained by national leadership and partnerships on health and the provision of timely, responsive and evidence-based advice and action on health issues.**

This is a general statement that applies to Health Canada's activities in the Drug Strategy as much as it does to any other of its work. The mid-term review would ask what this vision implies for the Strategy and what have Strategy officials done to assimilate this vision into their work? The Canada's Drug Strategy Secretariat has not yet developed a position on this. However, any position that they develop might take some of the following ideas into account.

Determinants of health

A determinant of health is a cause that, usually in concert with other causes, brings about a particular state of health, either of an individual or a population. The state of health brought about may be anywhere on the spectrum of poor to excellent. Determinants are neutral in this regard. What are the particular things that are the causes of particular states of health is an empirical question that can be answered only through empirical research. It is not an ideological question.

Determinants normally work in sets and often determine each other. Often there are "chains of determinants", chains of causes that, as a set, result in a particular state of health. Consequently, one should not refer to THE determinant of health or, in an unqualified sense, to the most important determinant of health. As causes, each member of the chain of determinants is active in bringing about its consequent state of health. A change in the chain of determinants will change the health outcome. Determinants can be either positive or negative, that is, conducive to a positive state of health or to a negative state of health. And both positive and negative determinants can be in the same chain.

Why care about determinants of health?

Because determinants usually work in chains or groups, each member of which may be just as efficacious as any other, interventions designed to improve health status may be rendered ineffective by one member of the chain if it is ignored in the intervention. As a result, a program may be ineffective or less effective, and valuable resources wasted.

A classic example of this brought about the healthy public policy movement and the resulting concern over the determinants of health. The story in brief goes something like this. In the early 1970s, governments were hopeful that disease prevention could be made vastly more effective by changing the health behaviours of individuals. Health promotion, especially in the form of social marketing, came to be seen as an effective way to improve the health of a population, and many such programs were created. However, these programs were not as successful as originally hoped for certain sub-populations, and explorations into why this should be so discovered determinants of health other than individual lifestyle and behaviour, other determinants that to a large extent thwarted the potential of social marketing. Some of these were socio-economic.

The lesson to take from this sort of example is that a government intervention cannot be guaranteed success if it concerns only some determinants in a chain. In the case of lifestyles or health behaviours, while they are determinants of health, they are only part of a chain, and a part relatively close to the health outcome. If one goes "farther up the chain", one will discover what it is that determines lifestyle, and this cause may well affect the degree to which a lifestyles intervention will be effective for a population or various sub-populations. Some Drug Strategy programs attempt to work at what are taken to be deeper causes of substance abuse, for example, those programs that attempt to build self-esteem in youth. The basic idea is

that the sort of message found in the "Just Say No" programs will not be effective for those with insufficient self-esteem to say no to their peers, that improved self-esteem will help young people deal with this sort of peer pressure or other negative influences.

A determinants approach

A determinants of health approach, then, is an evidence-based approach to designing interventions to improve the health of populations that utilizes information specifically about the full range of determinants of the health status of a population. There are many possible ways of using the determinants of health approach, the obvious being to select the targets of interventions. However, there is a somewhat more subtle but historically justified use of the determinants as a test for any possible intervention. The test would work in this general way. Of any intervention directed towards any determinant, ask if its effectiveness will be mitigated by determinants higher up in the chain of determinants. If the answer is no, then, all other things being equal, one should proceed with the intervention. However, if the answer is yes, then one can either develop an intervention for this higher determinant, or, if this is inappropriate, determine the resulting cost-effectiveness of the original intervention and decide to proceed or not. The determinants approach can, then, be utilized also as a cost-control device just as much as it can assist in designing effective programs.

Determinants of health and other Strategies

Current thinking about what are the major determinants of health indicates a convergence of determinants for a number of different health conditions that Canada's Drug Strategy deals with, some of them through sunsetting programs. Many of the conditions associated with poor health are found in greater concentration among those with low income, low levels of education, high levels of unemployment, and so on. Thus, some conclude that low income and the other conditions are important determinants of comparatively poor health and are manifest in such unhealthy behaviours as tobacco use, substance abuse, family violence, gambling, poor eating habits, and so on. Details aside, the point is that the determinants of health approach indicates that many different unhealthy behaviours and conditions of ill health can be traced to common causes. This approach would advocate dealing with these different problems as related problems, related through their root causes.

This comes as no real surprise. We have known for a very long time that many programs serve the same client group, that often it is the same people who receive substance abuse services, employment

services, family violence services. The determinants of health approach, then, suggests blurring the divisions between some health problems related through common causes and at least giving attention to the ways that different programs approach shared client groups. If nothing else, the determinants of health approach should be cause for greater co-ordination between programs that share clients, if not for radical program re-design (that targets primarily populations rather than problems) and perhaps amalgamation. This applies to multi-departmental sunsetting initiatives as much as it does to individual programs.

ISSUES FROM THE DEPARTMENTS:

Solicitor General

The approval of funding by Cabinet for Canada's Drug Strategy Phase II did not include any resources for international activities with regard to substance abuse. This placed the Ministry of the Solicitor General in an awkward position given its direct lead or partnership responsibilities in a number of international organizations (e.g., CICAD, the G-7 Financial Action Task Force, the Caribbean Financial Action Task Force, and the United Nations Drug Control Program). A-base dollars were not available within the Ministry to fund those responsibilities and, therefore, resources designated for demand reduction are being used for this purpose. It is the intent of the Solicitor General Secretariat to continue so using these resources until the end of Phase II of the Strategy. There is now no plan for how these international costs will be funded beyond March 31, 1997.

Canadian Heritage

The Canadian Centre for Drug-Free Sport and Fair Play Canada will merge effective October 1, 1995. The merger will bring together organizations and activities dealing with ethics in sport. It is intended that the merger will strengthen educational endeavours related to ethics in sport, including matters related to drug use. It is also intended that the merger will result in some administrative savings, so that programming resources may be preserved.

DRUG-RELATED HARM TO INDIVIDUALS

Canada's Drug Strategy was introduced in 1987 as a special measure to counter a perceived increase in the severity of substance abuse problems in Canada. The 1992 framework document described a range of harms that the Strategy will attempt to reduce. One of these is premature death. This report will present some mortality data from the years 1987 to 1992, the most recent year for which Statistics Canada data are available. These data do not give reason for optimism and should be of concern to Canada's Drug Strategy officials. However, they are presented primarily as another facet of the Strategy's

environment, not as in themselves an indicator of the effectiveness of Canada's Drug Strategy.

DRUG OVERDOSE DEATHS IN CANADA, 1987-1992

Drug type	1987	1988	1989	1990	1991	1992
Opiates	56	55	58	82	133	148
Cocaine	59	80	99	65	92	78
Barbiturates	45	34	34	29	30	29
Alcohol	120	116	112	110	155	178
Tranquilizers	27	20	24	23	17	15

Although these Statistics Canada data indicate a slowly reducing incidence of overdose deaths due to barbiturates and benzodiazepine-based tranquilizers, the trends for the opiates, of which heroin is the most common, cocaine, and alcohol give cause for concern. From the time that the Drug Strategy began in 1987 until 1992, heroin deaths have increased by 265%, cocaine deaths have increased by 32%, and deaths due to alcohol poisoning have increased by 48%. (Note that overdoses account for a small percentage of deaths attributable to alcohol abuse; consider, for example, cirrhoses of the liver, impaired driving, and acts of violence.)

Drug deaths in British Columbia

The data just presented do not tell the worst of it because they do not go beyond 1992. However, the province of British Columbia has experienced such an escalation of drug overdose deaths since 1992 that the province established a task force to study the problem; the Office of the Chief Coroner released in September, 1994 a report that includes more recent data for that province. The following numbers from 1993 are striking:

Drug Type	Deaths
Heroin	298
Cocaine	106
Alcohol	145
Total	549

This situation is clearly extraordinary and it might not be unreasonable to characterize it as a crisis because the number of overdose deaths far exceeds past patterns. At the time that this report was written, Canada's Drug Strategy had made no formal Strategy-wide response to the British Columbia situation. Canada's Drug Strategy regards the province of British Columbia as having sole jurisdiction over this situation, at least until the province indicates that federal involvement is appropriate. Accordingly, the Canada's Drug Strategy Secretariat is taking a position of waiting for a clear signal from the province of British Columbia before it reacts. Preliminary discussions between the province and Health Canada have begun regarding the authorization of physicians to offer methadone maintenance treatment, but as of yet no formal changes have taken place. Health Canada has received no specific request for action and has, therefore, not become involved beyond these preliminary discussions.

The federal government has a history of becoming involved with the provinces in crisis situations. It has in recent years responded swiftly and effectively to threats posed by tainted mussels and imported grapes as well as to natural disasters such as the Edmonton tornado. One is immediately led to draw a comparison with the responsiveness of the emergency measures organizations, along with counterpart organizations in other governments, who are charged with the responsibility to take action in the event of certain sorts of emergencies within Canada. One might be excused for expecting there to be an analogous capacity within the drug field where the severity of the harm can be very high.

However, there appears not to exist a plan for the federal government to respond to drug-related emergencies, either on its own or in concert

with the provinces. Further, as noted earlier in this report, with the disbanding of the Federal-Provincial Advisory Committee on Alcohol and Other Drug Problems, there no longer exists an organization with a clear responsibility for federal-provincial co-ordination on d issues, including extraordinary or emergency situations. The situation in British Columbia poses a challenge to the Canada's Drug Strategy partnership, one piece of which is to be federal-provincial, to take joint action in extraordinary situations.

Although they are not confined to Vancouver, most of the overdose deaths have occurred in that city. Therefore, the problem is confined to a relatively small area and could become a good test case for the federal harm reduction approach in the drug field, should the federal government be asked to become more involved. The British Columbia situation is one where a harm reduction approach to substance abuse should have something to offer. It must be noted, however, that Vancouver is not the only city with recently elevated overdose death levels. Toronto and Montreal have also experienced increases, albeit, not to the same extent. Without either a plan or an organizational capacity, it would appear that the federal-provincial partnership has work to do to define what a harm reduction approach to substance abuse involves and implies for federal government and joint federal-provincial action in extraordinary situations.

endnotes

1. These are taken from Kenneth Kernaghan's "Partnership and Public Administration. Conceptual and Practical Considerations", **Canadian Public Administration**, Vol. 36, No. 1, pp. 57-76.

2. In Ontario, the Addiction Research Foundation still exists as a specialized addictions research agency. However, it now reports through the Ministry of Health.